



16 February 2002

**Blears finds
extra £4.1m for
dispensing fees**

**RPSGB extends
CPD scheme to
5,000 members**

**Modernisation
Fund pays out
in Scotland**

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aciclovir



References: 1. Spruance SL. Seminars in Dermatology 1992; **11**(3): 200-206. 2. Data on file, GlaxoSmithKline, 1999.





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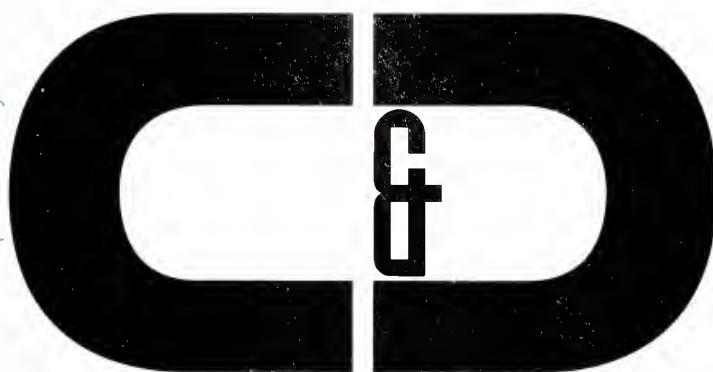
NYTOL NIGHTTIME HERBAL SLEEP AID: Product Information. Presentation: Tablets, each containing: Hops 30mg; Dogwood Jamaica 90mg; Dry Extract of Wild Lettuce 5=1.54mg; Dry Extract of Passiflora 5=1.36mg; Dry Extract of Pulsatilla 3=1.15mg. **Uses:** A traditional herbal remedy to promote calmness and natural sleep. **Dosage and administration:** Two tablets at bedtime. **Contraindications:** None known. **Precautions:** Keep all medicines away from children. If you are pregnant, seek medical advice. Not recommended in early pregnancy and lactation. **Side effects:** None known. **Legal category:** GSL. **Product licence number:** 00250/0005R. **Product Licence Holder:** Porter's (Herbal Supplies) Ltd, Wigton WN1 2SB. Further information is available on request from: Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** £4.49 for 28 tablets. **Date of last revision:** January 2002.

NYTOL AND NYTOL ONE-A-NIGHT: Product Information. Presentation: Nytol: White uncoated oblong caplets imprinted with an 'N', each containing 25mg of Diphenhydramine Hydrochloride BP. Nytol One-A-Night: White coated oblong caplets imprinted with 'N50', each containing 50mg of Diphenhydramine Hydrochloride BP.

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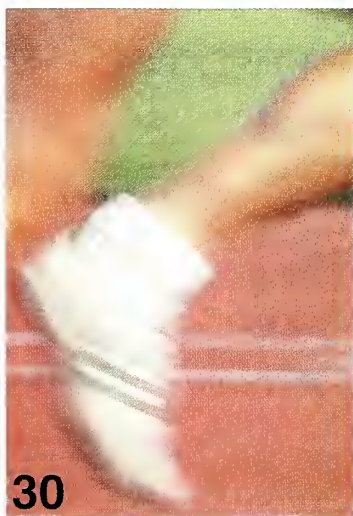
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Editor
Patrick Grace, MRPharmS

Assistant Editor
Guy L'Amable, BA

News Editor
Charles Gladwin, MRPharmS

Business Editor
Nina Keller-Henman, Dipl Biol

Contributing Editor
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Reporters
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Gary Paraguri, MRPharmS

Art Editor
Tony Lamb

Production Editor
Fay Jones, BA

Production Sub-Editor
Lori Pimlott

Editorial secretary
Jan Powis
Editorial (tel): 01732 377487;
(fax): 01732 367065;
chemdrug@cmpinformation.com

Price List
Colin Simpson (Controller),
Daren Larkin, Maria Locke
Price List (tel): 01732 377407
(fax): 01732 377559

Group Advertisement Manager
Julian de Bruxelles

Group Advertisement Executives
Quentin Goldan, Mark Walley

Classified Executive
Debra Thackeray

Advertisement secretary
Elaine Steele
Advertising (tel): 01732 377621,
(fax): 01732 377179

Production
Katrina Avery

Publishing Director
Fergus Wilson

Special Projects Manager
Steve Bremer MRPharmS

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Blears allocates another £1.4m

Health minister Hazel Blears has re-determined the 2001-02 pay settlement for pharmacy contractors in England and Wales, with an extra £4.1 million being made available.

The increase means that there will be a 4.2p increase in the professional fee for prescription items in February and March, up from 87.4p to 91.6p.

A Department of Health letter to the Pharmaceutical Services Negotiating Committee now acknowledges that it is within the minister's discretion to decide how the annual remuneration

package is made, rather than having to stick to a particular formula. This was something PSNC had threatened to challenge in the courts (*C&D* December 8, 2001, p6).

The letter also indicates that Ms Blears realises the immense impact on the morale of pharmacists the pay imposition for 2001-02 had when it was announced in November (*C&D* November 24, 2001, p4). Although the global sum increased 3.7 per cent, an increase in the number of prescriptions meant the previous global sum had been overspent, so

the DoH cut the dispensing fee 10p as a clawback. The money announced this week reduces the size of the clawback.

Kevin Guinness, head of pharmacy and prescriptions branch at the DoH, said in the letter: "We have come to the view that the difference between forecast and actual dispensing volume was exceptional. We have also taken note of the PSNC's continued commitment to taking forward *Pharmacy in the Future*."

PSNC gave a "measured" response to the sum. Its chief executive Sue Sharpe said the minister's announcement meant that PSNC was dropping the threat of legal action on this matter. Mrs Sharpe said that she appreciated that this was some acknowledgement of the impact of the imposition, and noted: "This is the first time that we have ever got money after an imposition."

"We do not pretend that the new determination is satisfactory, far from it. The whole process, including the inordinate delays in the DoH, as well as the outcome, has been unsatisfactory. The need for a new contract has been underlined by what has happened this year."

PSNC representatives were to meet Ms Blears on Wednesday after *C&D* went to press. Mrs Sharpe said that the meeting would be to discuss the future rather than rake over the past.



PSNC chief executive Sue Sharpe was guest speaker at a meeting of the North Western Region LPCs last week. Pictured with Mrs Sharpe at the meeting, sponsored by Alpharma, is Neil Maxwell, the NW Regional PSNC representative

Second wave of medicines management pilots

Forty sites have been selected for the second wave of the collaborative medicines management pilots. Each will receive £76,000 this year.

Richard Seal of the National Prescribing Centre, which is hosting the pilots, said: "Hopefully all will involve community pharmacists, but we won't know exactly how until the detailed action plans are submitted."

Most of the first-wave pilots, announced last July, have involved community pharmacists to a greater or lesser extent.

Health Minister Hazel Blears believes patients are already seeing benefits from pilots in the first 26 sites. The patients are having their regular medication reviewed more often and have better access to information.

The 40 new sites are:

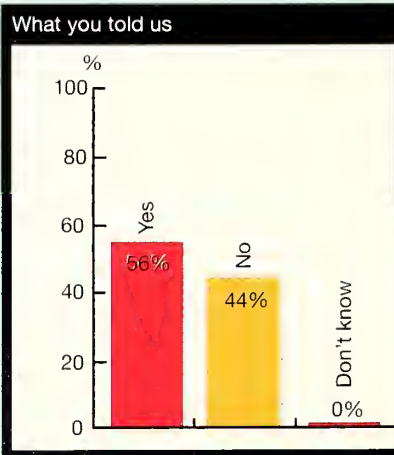
- Eastern region – Castle Point & Rochford PCG, Fenland PCT, Luton PCT, South Peterborough PCT, Southend PCT, Watford and Three Rivers PCT.
- London region – Balham, Tooting & Wandsworth PCG, North Lambeth PCG, Redbridge PCT, Walthamstow, Leyton & Leytonstone PCT.
- North West – Central & South Knowsley PCG, Central Cheshire PCT, Heywood & Middleton PCG, North Manchester PCG.
- Northern & Yorkshire – Durham & Chester-le-Street PCG, Langbaugh PCG, Leeds South PCG, Middlesbrough & Eston PCG, North Bradford PCT, Wakefield West PCT.
- South East – Ashford PCG, Guildford PCG, New Forest PCT, West Elmbridge & Surrey Thames PCT.
- South West – Bristol North PCG, Bristol South & West PCG, North Devon PCT, Plymouth PCT, Taunton & area PCG, West of Cornwall PCT.
- Trent – Ashfield PCT, Doncaster Central PCT, Leicester East PCT, Mansfield PCT, Sheffield West PCT, West Lincolnshire PCT.
- West Midlands – Burntwood, Lichfield & Tamworth PCG, Hodge Hill PCG, Shropshire County PCG, Wyre Forest PCT.

Questiontime

Do you think the £4.1 million extra the Department of Health has found to pay pharmacists for February and March prescriptions will help increase morale in the profession?

● Yes ● No ● Not sure

You can record your vote on our website: www.dotpharmacy.com Question time appears on the home page. Select your answer and then click on the "vote" box. Your answer is automatically collated. You have until noon on February 19 to cast your vote. We will publish the result in *C&D*, February 23. Last week we asked you: Do you see pharmacists as key advisors for information about the MMR vaccine?





Sue Young, Barking & Havering Health Authority chairman, and Hemant Patel, LPC secretary, welcome Health Minister Hazel Blears to the launch of the medicines management service at Maylands Surgery, Hornchurch

Medicines management gets cash boost in Essex

Pharmacists in Barking & Havering have secured £500,000 funding for a medicines management scheme involving patients over 65 who are taking more than four medicines.

The scheme is not a pilot, but a new service, to be evaluated over two years. Initially over half (42) of the contractors in the area are updating their knowledge of cardiovascular disease, NSAIDs, gastro-intestinal disease and diabetes, although the training will be flexible to cope with changing needs.

Accredited pharmacists will then start collaborating with local GPs to help older patients on long-term medication. Some pharmacists should be ready to start by the end of March, while the remainder should have finished the training by the end of June.

The Health Authority will pay £45 for each intervention, with about 50 interventions per pharmacist expected. Pharmacists will receive nearly £1,000 on completion of the training, plus the £1,000 course fees. But the scheme is expected to save £36

per patient in drug costs and £20 each in indirect costs such as hospital admissions – and that is after paying for the pharmacists' input.

Professor Clare Mackie and colleagues at Robert Gordon's University, Aberdeen, have devised the training, which includes interactive learning from patient interviews on CD-ROM. The modules are part of a postgraduate course in prescribing science. The Health Authority is also providing laptop computers for information transfer.

Launching the service in Hornchurch on Tuesday, Health Minister Hazel Blears praised the pharmacists for their initiative. She said that, in the face of so much criticism of the NHS, "it gladdens the heart" to see creative and imaginative people developing such challenging ideas. She hoped to highlight their efforts in a House of Commons debate on the care of the elderly the following afternoon.

The minister spent over an hour speaking to local pharmacists about this and other projects they were running,

including smoking cessation.

Barking & Havering Local Pharmaceutical Committee has been working on the medicines management scheme for two years, under the leadership of secretary Hemant Patel.

"The Health Authority, GPs, community health councils and academics have helped us steer the project," he told *C&D*. "It differs from the PSNC-led medicines management pilots in that it is based in one health authority and covers more than one therapeutic area. The health authority appreciates that there will be a reduction in prescription numbers, so is compensating contractors for their high quality professional input.

"Another benefit is that the pharmacists are taking part in work-orientated CPD, rather than CPD for its own sake, and the professional development is likely to continue."

Sharon Morrow, the Health Authority's pharmaceutical adviser, told *C&D* she hoped the service would continue after two years, depending on the evaluation.

6,000 blank scripts hijacked in London

Pharmacists across London are warned to be on the alert for forged prescriptions after a health authority van delivering blank prescription forms to GP surgeries was hijacked on Tuesday.

The 6,000 FP10C forms went missing in the Lambeth, Southwark & Lewisham HA area. Since they are computer forms they did not carry any GP practice details on them. The serial numbers on the three batches of 2,000 forms are:

- 14351280011 to 14351300004
- 14110260010 to 14110280003
- 14110320016 to 14110340009.

The police have been informed.

Pharmacists are advised that if they are presented with a suspect script they should contact their local police station, and Pat Roberts at Lambeth, Southwark & Lewisham HA (tel: 020 7716 7000 ext 7918).

Osteoporosis Update in error

The Update article on osteoporosis which appeared in *C&D*, January 26, p23, included doses of vitamin D in milligrams instead of micrograms. Question 4 on MCQ 2223, published February 2, printed the correct quantity of vitamin D (20mcg).

Pharmacist for elderly appointment

Northern Ireland's Southern Health Board is looking to appoint a pharmacist responsible for looking after medicines for the elderly.

The job will include three main duties:

- medication review in a residential setting
- co-ordinating the training of carers in administration of medicines
- developing the community pharmacists' role in delivering pharmaceutical care in a residential setting.

The post will be advertised by the end of March.

Clinical governance goes on the road

Boots is holding a series of clinical governance roadshows for its pharmacists across the country. The evening events will be led by Stephen Eastham, head of clinical governance and either Digby Emson, pharmacy superintendent or Steve Churton, assistant pharmacy superintendent.

Among the issues to be discussed will be the implications of the NHS Plan.

RPSGB sets out future options

The future remit and function of the Royal Pharmaceutical Society is the subject of a paper due to be published this Friday.

The discussion paper, which is intended to help the Society's modernisation steering group formulate policy, is being sent out to pharmacy bodies, the Society's branches, and patient, consumer and health organisations. It sets out:

- the RPSGB's current remit and function
- the constraints imposed by legislation, the Society's Charter, government policy and establishment of an overarching regulator for the health professions
- future options and their pros and cons.

Society president Marshall Davies said: "No decisions have been taken yet about our future remit or functions. The steering group needs the views of interested parties to help formulate its proposals."

The paper can be viewed at www.rpsgb.org.uk.

Honorary fellowship for GSK chairman



Sir Richard Sykes (right), chairman of GlaxoSmithKline, has been awarded an honorary fellowship by the Royal Pharmaceutical Society.

Only 15 honorary fellowships have been awarded in the 49 years since the Society's Council was given the right to bestow them.

'Unfairly treated'

Granada Television has had to broadcast details of the Independent Television Committee's adjudication concerning a Liverpool pharmacist on Thursday evening, following a ruling from the Broadcasting Standards Commission (C&D, January 12, p7).

The BSC said pharmacist David Taylor had been unfairly treated when *Tonight with Trevor McDonald* investigated sales of emergency hormonal contraception to under-age girls. Details of the adjudication also appeared in the *Daily Mail*.

Jeremy Clitherow, local pharmaceutical committee secretary for Liverpool, said he was very pleased to see Mr Taylor's pharmacy vindicated.

RPSGB to extend CPD framework

Mandatory continuing professional development came a step closer this week as the Royal Pharmaceutical Society announced plans to roll out its CPD framework to involve at least 5,000 pharmacists.

Those taking part will be advised that in three to five years' time they may be among the first pharmacists to be invited or required to produce some or all CPD records for their revalidation to practice.

Implementation of the programme will begin in late 2002. Those who will fall under its umbrella will come largely from one area of Great Britain, to be determined following consultation. Participants will be sent a CPD pack in the autumn to enable them to keep plans and records of their CPD.

The roll out of the CPD framework was approved at February's Council meeting. It is a key part of the Society's modernisation programme (*see*

p15) where determining competence and fitness to practice will be part of the RPSGB's regulatory function. Society president Marshall Davies said: "The CPD framework is an opportunity to give the Society a head start towards becoming a world-class regulator."

The RPSGB piloted a portfolio-based CPD system supported by facilitators in three areas in 2000-01. Around 70 per cent of pharmacists offered the scheme participated, and six to seven months after starting 40 per cent of them had submitted a CPD portfolio. Women had higher submission rates on average than men.

Dr Robert Dewdney, head of the Society's education division, has consistently warned that in future competencies would be linked to specialities; members might not have the right to practice in different zones of the profession.

CONTRACT

Oxygen supply permitted across HA boundaries

Pharmacists will be able to provide domiciliary oxygen services for patients living across health authority boundaries, from April 1.

Payment will be made by the health authority in which the pharmacy is situated.

There will be no need for health authorities to pay pharmacists on an *ex gratia* basis for providing services to people in other areas. Nor should health authorities pay pharmacists outside the area, as contractors can claim from their own health authority.

The change is expected to give patients more choice, according to a letter being sent by the Department of Health to health authority managers of local pharmacy budgets.

A Department spokeswoman has confirmed that, subject to legislation, there would be no restriction on the area in which the contractor could offer oxygen services.

Pharmacists' fees are to be determined locally, after

consultation with local pharmaceutical committees. As before, each health authority will receive separate allocations for oxygen services and for hardware. The former will be used to pay pharmacy contractors for delivering and collecting cylinders, and giving professional advice. The hardware budget is for reimbursing contractors for holding oxygen sets and to pay compensation for lost or damaged sets.

Transferring between the two budgets is not permitted. Underspend on hardware should not be used to increase the services' budget or vice versa.

Responsibility for domiciliary oxygen services will remain with health authorities until PCTs take over in October, subject to the NHS Reform Bill passing through Parliament.

An annex shows the provisional allocations for 2002-2003.

For more information:

www.doh.gov.uk/lpb.htm



Pharmacist Nishit Patel is seen wearing an osteoporosis simulation suit to demonstrate to Health Minister Hazel Blears how the disease restricts mobility and causes height loss. Mr Patel is running an osteoporosis project in Yardley's Chemist, Hornchurch. He is not receiving a fee but says he is taking part "because I am interested". The pilot, sponsored by Procter & Gamble, will look at the feasibility of providing osteoporosis services through pharmacy. It will be evaluated independently.

Antibiotic prescribing

More training for pharmacists on the appropriate use of antibiotics is among suggestions in an action plan for Northern Ireland.

The Antibiotic Resistance Action Plan recommends that undergraduate and postgraduate courses place greater emphasis on optimal antibiotic usage. Among other recommendations are:

- to encourage rational prescribing based on clinical and microbiological diagnosis
- prescribers should receive anonymous data
- local antibiotic prescribing review groups should be set up, to include pharmacists
- antibiotic prescribing by telephone should be audited and actively discouraged
- effective measures should be implemented to reduce patient expectations
- health boards should implement evidence-based antimicrobial guidelines across the primary-secondary care interface.

The Department of Health, Social Services and Public Safety welcomes further suggestions, and a workshop on March 20 will discuss implementation plans.

For more information:

www.ni-executive.gov.uk/press/hss.htm



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'Pharmacist prescribing set for 2003'

How will pharmacy services develop in the future? That was the vital question addressed by key industry figures at a conference in London recently. Adrienne de Mont reports

Pharmacist prescribing should become a reality by mid-2003, according to Jim Smith, the Department of Health's chief pharmaceutical officer.

The legal powers are in place and informal discussions with the Royal Pharmaceutical Society finished last month, he told a conference on "Developing future pharmacy services." He hoped formal consultations would start in April, leading to regulations by the end of the year.

"It's a tall order, as large amounts of work have to be done. But ministers are pushing very hard," he said.

The first priority would be supplementary prescribing, with pharmacists working in partnership with a responsible independent prescriber in repeat prescribing or in asthma, diabetes or anticoagulant clinics. The next phase, independent prescribing, "is not on our agenda in the short term", he said.

Mr Smith was aware that workforce pressures and the increasing workloads of pharmacists posed a threat for proposed new roles. Pharmacist shortages were now at their worst, but could only get better. There were 27 per cent more students passing through pharmacy schools, but this had not yet become evident because of the "fallow year".

In the long term there was a need to look at supervision, and training support staff to enable pharmacists to maximise their contribution to the safe and effective use of medicines.

"But I can't offer any short-term fixes," he said.

One factor working in pharmacy's favour was the increasing emphasis on patient safety in the NHS and a growing recognition that medicines management was a key issue. Mr Smith thought medicines management would eventually

become a formal part of local pharmaceutical services.

The DoH was committed to a new national contract for community, but had not yet started work on it.

"There will not be a better - or possibly another - opportunity to reshape pharmacy services," he said.



Jim Smith: independent prescribing is not on the DoH's agenda in the short term

Integrated IT

Changing roles based on information provision, repeat dispensing and medicines management will require integrated IT to ensure seamless care. This, coupled with increasing pharmacy workloads, will make it necessary to reconsider how community pharmacists process prescriptions, said Andy Murdock, Lloydspharmacy's superintendent pharmacist.

Automated dispensing could help improve accuracy and create time for pharmacists to interact with patients.



Andy Murdock: wants the Government to spend more money on healthcare

Integrated PMRs could reduce transcription errors when patients move between hospital and primary care, so all health professionals should have access to the NHSNet where necessary. This will require more finance and commitment from the Government, he said.

The Health Service, he added, spends less on IT per employee than any other sector of the economy. Banking, for example, spends about nine times as much.

Control of repeat dispensing by pharmacists, together with electronic prescribing, could be a major step in reducing risk and aiding patient compliance. But he wondered why the Government was trialing paper-based schemes when resources could be redirected towards establishing the critical IT structure.

Mr Smith said there was a clear commitment to link community pharmacy to the NHSNet, but the GP and hospital sectors were a higher priority at present.

Legal pitfalls

What standards should apply to prescribing by pharmacists?

Jon Merrills, consultant pharmacist and barrister, said they would not be the same as those required of doctors, who were the traditional experts, but would be those of a "reasonable prescribing pharmacist."

"But given the importance of prescribing and the potential for damage, I would not expect the difference to be great.

"You cannot profess experience on one day and deny it in court the next," Mr Merrills said.

The law would not allow for a learning curve, he warned, so pharmacists starting to prescribe would be expected to be as good as if they had been doing it for years.

● The Community Pharmacy Medicines Management Project should go live in the next few weeks, following approval by local ethics committees. Mike King, PSNC's head of professional development and LPC services, said he hoped enough evidence would have been collected by the end of the year to support community pharmacy roll out of medicines management.

The Government is soon to announce the second wave of 50 more pilot sites in the collaborative medicines management scheme being co-ordinated at the National Prescribing Centre.

● 2006 would be the earliest possible date for ETP to be in place nationwide, predicted Ewan Davis, consultant to Pharmed, which is involved in the TransScript ETP pilot.

National schemes might start in 2004 if the DoH decided to go ahead, he said. He thought the DoH would take the best aspects of the three pilots, add further modifications and define standards.

"Developing future pharmacy services" was organised by IBC UK Conferences, www.healthcare-info.co.uk and tel: 01932 893852.

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at least 3 times per week. For babies and infants a 5ml measure for a bath and daily application is recommended. Balneum Plus can also be used in the shower by applying evenly without dilution and rinsing away excess by showering. **Contraindications, warnings etc:** Contraindicated in patients hypersensitive to any of the ingredients. Care should be taken to guard against slipping in the bath or shower. Avoid contact of undiluted product with eyes; if this occurs, rinse immediately with water. **Package quantities:** Bottles of 500ml. **MRRP cost:** £13.22 **Legal category:** GSL **Product**

licence number: 00327/0110. **Product licence holder:** Crookes Healthcare, Nottingham, NG2 3AA. **Date of Preparation:** November 2000. **References:** Cork MJ. Complete Emollient Therapy. In: The National Association of Fundholding Practices Yearbook, 1998. The Independent Community Pharmacist 1999; April 52. Kopecka B and Borelli S. Praxis 1964; 53(48):1630-32. **CHCSK00197 CROOKES HEALTHCARE**



Martindale en Espagnol

A Spanish version of *Martindale* will be the first book published by Pharma Editores, a newly created company in an initiative between the RPSGB's Pharmaceutical Press and Spanish publishers STM Publishing. The release of a direct translation of the 33rd edition of *Martindale* is expected for April.

AAH launches training programme

AAH Pharmaceuticals is launching a category merchandising programme for pharmacists and their staff. The three-module programme, which is to be held away from the pharmacy, includes basic business skills as well as basic and advanced category management. The courses cost £90 for Vantage members (£160 for two delegates) and £120 for AAH customers (£200 for two delegates).

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Valupak, BR Pharmaceuticals' range of minerals, herbals and supplements, is now available through UniChem. For more information, call BR Pharmaceuticals (customer sales), on 0113 275 0000.

AZ divests dental range

AstraZeneca has sold its range of dental anaesthetics to Dentsply Ltd for an undisclosed sum. The rights for Citanest (4 per cent injection, 3 per cent with octapressin), Lignostab, Xylocaine (2 per cent with adrenaline) and Xylotox will be transferred to Dentsply on February 15. As of next week, AZ will no longer provide the medical information for the product range. For more information, e-mail richard.mcgowan@dentsply-gb.com, or call 01932 837 279.

TEVA bids for Bayer Pharma SA

Teva Pharmaceutical Industries Ltd, the Israeli parent company of APS Berk, has made a firm bid for Bayer AG's generics business in France, Bayer Pharma SA. The offer covers the production site in Sens and Bayer Classics, a French supplier of generic pharmaceutical products.

Teva said the potential acquisition was in line with its plans to enhance its activities in Europe. Over 80 per cent of Teva's sales are in North America and Europe.

Modernisation fund backs 10 Scottish pharmacies



Drive-Thru pharmacy: already a common sight in the USA

A drive-through pharmacy planned by the Scottish chain, Munro Pharmacy, is one of 10 projects receiving funding from the Scottish Executive's £15 million Primary Care Modernisation Fund.

Of the £750,000 available in the third tranche of the programme, £548,000 has so far been allocated to Scottish pharmacies, with another £202,000 still under consideration (see table).

The Munro Pharmacy branch in East Kilbride received £45,000 to develop local authority social work and extend drug misuse services in planned new premises. The drive-through pharmacy will be built as part of the relocation. It will have two windows and around 90 parking bays. It is due to be completed in June and will

offer an extended-hours service.

A trained dispenser will enter the details of the medication into the PMR system at the first window, with the prescription handed out by the pharmacist at the second.

Dianne McGroary, Munro Pharmacy's retail director, said that if successful the pilot

could in time be rolled out to customers of Munro's wholesale division.

The highest grant, of £124,000, was given to Mitchell's Chemist in Dornoch, to install a lift and create a confidential area on the second floor.

Private counselling and consultation areas are a key part of most approved projects, while medication reviews, health counselling and drug counselling are among the professional services to be developed.

Grant Bannermann, who owns the JB group of pharmacies, received £80,000 for work on two of his branches and hopes to enhance its ethical and clinical focus by redressing the pharmacy-retail balance.

Frank Owens, chair of the Scottish Pharmaceutical General Council, added that "this initiative, together with the opportunity for community pharmacists to prescribe for certain patients suffering minor illness, should do much to ease the patient's journey of care".

Mitchell's Chemist, (Dornoch)	£124,000
Moss Pharmacy (Dundee)	£90,000
JB Pharmacy (Drumchapel, Greater Glasgow)	£60,000
JB Pharmacy (Coatbridge)	£60,000
Colinton Pharmacy (Lothian)	£60,000
Dykes Road Pharmacy (Knightswood, Greater Glasgow)	£60,000
Victoria Road G42 Pharmacy (Cathcart)	£60,000
Munro Pharmacy (East Kilbride)	£45,000
Dun's Pharmacy (Borders)	£21,250
J Dickson Pharmacy (Viewpark)	£8,000

Elan's accounting practices under investigation in the USA

The US Securities and Exchange Commission, the American equivalent to the Serious Fraud Office, has launched an investigation into the accounting practices of Elan Corporation.

The investigation centres on two Bermuda-based businesses, into which Elan has put the stakes it holds in several biotechnology companies. If these had been included in the official accounts, Elan's indebtedness would have

been almost \$3 billion (£2.1bn), not \$2bn (£1.4bn), as reported.

A spokesman for Elan insisted that the company had not done anything illegal and had at all times adhered to the rules of US and Irish GAAP.

The Serious Fraud Office confirmed that Elan was not currently under investigation in this country. However, only a minority of Elan shares are traded in London. Most are

traded on the New York and Dublin stock exchanges.

Elan also vowed to defend itself vigorously in a class-action brought against the company in America.

The company had earlier reported a 22 per cent increase in revenues to \$1.9bn (£1.34bn) and pre-tax profits of \$714m (£502m). Meanwhile, Elan's share price tumbled more than 50 per cent to £10.45, down from £20.55.

Legal action taken to protect Cipramil patent

Lundbeck Ltd, the manufacturer of Cipramil (citalopram hydrobromide), is taking legal action against Alpharma Ltd over an alleged breach of patent.

An injunction case is due to be heard at the High Court in London in the next few weeks and has already been extended to other companies. A similar case is being brought in the Netherlands.

The patent covers the production process used to manufacture Cipramil and is not due to expire for at least five years.

A different production process, for which the patent ran out in January, is no longer used by

Lundbeck as it was found to be more troublesome and less cost-effective.

Lundbeck's managing director, Jarne Elleholm, said the company was determined to enforce its intellectual property rights.

Meanwhile Alpharma confirmed that proceedings had been initiated and that it was "close to obtaining a marketing authorisation for citalopram tablets in the UK. As often occurs in these cases the originator (in this case Lundbeck Ltd) is trying to delay the start of generic competition."

The case is the latest in an

increasing number of lawsuits brought by companies to protect their patent rights.

AstraZeneca's case in relation to Losec (omeprazole) is due to be heard this month while generic manufacturers will face GlaxoSmithKline over Seroxat (peroxitine) in March.

Richard Saynor, general manager of Generics UK, said there was a greater tendency among ethical companies to try and keep a patent by all means, including legal proceedings. His company is not involved in the Cipramil case as it has a licensing agreement with Lundbeck.

GSK stock swap gets underway

GlaxoSmithKline's stock swap programme is going live, allowing pharmacists to exchange out-of-date stock.

The scheme, first announced last October as part of Plus+ (see *C&D October 20 2001, p6*), allows pharmacists to swap stock up to the value of £100 five times a year.

Products which have passed their use-by date can either be exchanged for new stock of the same product or for Amoxil (250mg, 21 pack).

For more information:

Tel: 0800 221441

GSK (Plus+ customer care centre)

Boots invests £120m in effort to put BHI in top 10

Boots is to invest £120 million in its over the counter medicines division, Boots Healthcare International (BHI), with the intention of bringing BHI into the global top 10 of OTC manufacturers.

Boots' four year strategy for BHI includes increased support for the divisions' three core brands – Nurofen, Clearasil and Strepsils – as well as enhanced investment in new product development.

For the next financial year (2002 – 03) Boots will increase BHI's marketing spend by 20 per cent and raise the amount of money invested in new product development by 30 per cent,



BOOTS HEALTHCARE INTERNATIONAL

representing an additional investment of £20m.

Alongside its own-product development, Boots will also seek further acquisitions to achieve its profit target of £100m within four years. It is also said to be developing three new brands, which had recently been switched from Prescription-Only Medicines.

Last year BHI recorded sales of £362m and pre-tax profits of just under £60m.

Coming Events

FEBRUARY 18

Slough Branch, RPSGB

New Practices in Accident & Emergency, by Dr Chuck Merrill, consultant, Hillingdon Hospital, 7.15 for 8pm.

North East Lancashire Branch, RPSGB

CPR – Could You Do It? a hands-on evening with Resus Annie, 7.30 for 8pm at the Blackburn with Darwen PCT new HQ, Guide Business Centre, School Lane, Blackburn.

NICPPET

From Babies to Infants – the role of the pharmacist, at the Everglades Hotel, Londonderry, 7.30 for 8pm.

NICPPET

From Babies to Infants – the role of the pharmacist, at the Canal Court Hotel, Newry, 7.30 for 8pm.

FEBRUARY 20

Ayshire Branch, RPSGB

Pharmacist's Role in Drug Misuse, by Kay Roberts, area pharmacist, at the Piersland House Hotel, Troon, 7.30 for 8pm.

NICPPET

Counselling Skills, at the Fitzwilliam International Hotel, Antrim, 10am – 5pm.

FEBRUARY 21

NICPPET

Diabetes, at the Fitzwilliam International Hotel, 10am – 5pm.

FEBRUARY 22

Eastbourne Branch, RPSGB

Pharmacy Education in the 21st Century, by Professor Stephen Denyer, Brighton University, 8pm, in the Postgraduate Medical Centre, Eastbourne DGH.



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The Future of Pharmacy

Comment

from the Editor



"Re-determined" – a lovely word from the civil service book of words which might be defined as giving way without admitting fault. The extra £4.1m the DoH has thrown into the remuneration pot – half the overspend from the global sum due to higher than forecast prescription numbers – is a compromise. It is not half as much as contractors think is their due, but is tacit acknowledgement that PSNC was ready to make trouble and had a good story with which to embarrass the Government. As Kevin Guinness, head of Pharmacy and Prescriptions Branch at the DoH, told PSNC: "We consider there is a case for writing off some of last year's overpayment. We do not think it right to write it all off."

Whether you view the deal as a good thing or not depends on your perspective. One thing all contractors can agree on, though, is that this year's dogfight is not a long-term solution. Now it has been established that the global sum formula is not sacred, and there might be a link between productivity (ie script volume) and fees, there is a route, after all, which discussions on

a new contract could take. And if PSNC can build less "short termism" into any system it looks at, so much the better. Already contractors in England and Wales know there is absolutely no prospect of remuneration for 2002-03 being determined by April.

Elsewhere, there is good news. The Scottish Executive has been putting its Modernisation Fund to good use (*p10*). Barking & Havering LPC's medicines management scheme (*p5*) has received Blears' blessing. Its fees are sensible and it is a useful template for others to copy. There are funds to be found for deserving projects. The challenge is to build a case for government and primary care organisation to support them.

One thing all contractors can agree on is that this year's dogfight is not a long-term solution

Your views

The NPA's Georgina Craig and Rebecca Russell look at the implications of guidance on LPS

LPS – should it be welcomed or feared?

After another painful pay settlement, it is hard to believe that the Government has any goal other than getting "more service for less money" from LPS, and contractors are reluctant to leave the relative safety of the national contract.

However, LPS will happen – whether or not pharmacy contractors propose pilots. Primary care trusts are in the driving seat, and the NPA believes that it is important that those contractors who are likely to benefit from LPS shape the early pilots.

Experience from personal medical services pilots shows that early winners are often those who do less well from the current contract. For traditional pharmacy contractors, that means those with low dispensing volumes.

In addition, LPS can provide a way of attracting services to deprived areas with poor provision. LPS may also provide contractors in these areas with a

way of developing a business that would not be sustainable under the current contract, but which is needed by local people.

Existing pharmacy contractors can limit their liability and propose LPS pilots provided under the auspices of new bodies corporate. Packages of care for specific groups – diabetics, or CHD patients – could be developed through this route. New models of care for specific settings can also be tested, eg nursing homes or out-of-hours primary care centres.

But for pharmacy contractors as business people, there are also practical considerations:

- what impact will LPS have on goodwill values?
- what impact will it have on cash flow?
- how will lenders – banks, wholesalers – react to LPS? Will they be prepared to invest in LPS contracts?

● what impact will LPS have on the collateral of pharmacy businesses?

These issues will affect all contractors. Since LPS will enable new contractors to enter local markets, they may affect the goodwill and collateral of existing traditional contractors. If one contractor switches to LPS and the new approach proves popular, surrounding pharmacies may lose customers. This in turn may affect prescription volume.

HAs/PCTs will need to demonstrate that an LPS pilot offers value for money. Funds will be available from the global sum (equivalent to the

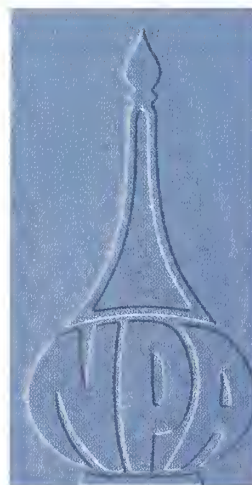
fees that the contractor would have attracted under the current system for those patients being cared for under LPS). In addition, PCTs

will be expected to identify funding for new elements of the service from within their unified budgets.

Final DoH guidance on LPS is not yet available but it is likely that there will only be a short time between the announcement of the application process and the deadline for submission of outline proposals.

If you are interested in getting involved in the first wave of LPS pilots, call the NHS Executive

Development team on 01727 858687 extensions 376 or 293 or e-mail nhs.dev@npa.co.uk.



BlackBAG

Tackling the thorny issue of MMR vaccination

Tony Blair has missed a golden opportunity to reassure the public over the MMR debacle, though balancing family privacy against the common good is never easy. The debate over multiple vaccination is, however, not academic. Rates of MMR immunisation continue to fall and we are verging on a return to days when childhood measles was the norm.

If spots were the only problem things would not be so bad. TV presenter Carol Vorderman didn't help with her flippant comment that before vaccination we just had measles "but nobody died". If only this were true. Measles encephalitis has a significant mortality and morbidity, not least from irreparable brain damage.

Inserting needles into your skin has never been an enjoyable pastime. Doing it by proxy to our children is even less popular, and any reason for not doing it at all will be leapt on by some parents.

We are verging on a return to the days when childhood measles was the norm

Pharmacists will probably be the first to recognise the epidemic when it hits. Measles may soon take on the status of a "self-inflicted illness". There will be a significant embarrassment factor in visiting the GP who offered MMR vaccination. Rather than risk the medical "I told you so", parents will self-medicate.

Good news for the OTC analgesic suppliers but a sad return to the days when children were deliberately exposed to the virus to get it over with. Measles is the second greatest cause of childhood death from infectious disease in the developing world. TV celebrities and doctors, who frankly should know better, all contribute to the crisis and leave us to pick up the pieces.

Dr Ian Banks is a practising GP in Northern Ireland

TOPICAL REFLECTIONS

Scotland takes the high road ... again!

Devolution is a reality in Scotland and, as a consequence, the working principles of healthcare in Scotland, England and Wales are diverging. With the publication of the Scottish Executive's pharmacy strategy the stage could be set for the gap to widen in the application and control of pharmaceutical services.

It certainly appears that community pharmacy is viewed more constructively by the Executive north of the border. There is a published timetable for change that, although still shy on resource implications, is

decisive on timing. Where Scotland leads, the rest follow has often been the case, but if the civil servants in England and Wales continue to drag their feet, the future application of different standards and priorities could lead to a different contract and legislative framework. England and Wales might then not necessarily follow.

This scenario must be avoided. It would be a nonsense if the UK evolved four differing healthcare systems that could restrict the free practice of pharmacists throughout its borders.

Time we saw the back of bulk generic packs

The new chairman of the British Generic Manufacturers Association, John Beighton, has pulled no punches in his recent criticism of the continuing saga of patient packs for generic drugs (*C&D February 9, p8*). He warns that some manufacturers' persistence in continuing to supply bulk packs is undermining the whole concept of patient packs and could result in more bulk packs, rather than fewer, being available on the market.

He has called on the Government to take a lead and he is right. Without Government pressure the bad generic habits of the past will persist, encouraged by the economic penalty community pharmacists have to pay to provide the patient packs they know are the most professionally appropriate.

It is against regulations to supply any drug without a patient information leaflet, but it happens every day of the week. Very few bulk packs supplied to community pharmacists have sufficient PILs for every patient. The result is that the habit of bottles of tablets dispensed without information persists.

The Government has sat on the fence for long enough. Voluntary encouragement has not worked. Patient packs must now be universally introduced and the only way to achieve this is by specifying standards of packaging and content within the licence. Pharmacists must also be required to adjust dispensing quantities to ensure complete patient packs are supplied against all prescriptions. Neither industry nor the medical profession can any longer be allowed to prevent pharmaceutical best practice.



Nothing wrong with the occasional placebo

The research conclusion in last week's *British Medical Journal* that cough mixtures are mostly ineffective is nothing new (*C&D February 9, p6*). The notorious black list recognised this fact, but compromised by offering a restricted list of available generic products for prescription on FP10.

This was because there was a social need for preparations which, even if they were therapeutically suspect, provided psychological help to patients with a self-limiting condition.

The placebo effect should not be dismissed out of hand and even more so when it comes to buying over-the-counter preparations. Patients are being exhorted to take responsibility for their own health, and a vital component of this process is the facility to choose between the many available OTC medicines.

The public is also encouraged to seek the advice of their pharmacist. I do not apologise for often recommending products that only provide a "feel good" effect. By agreeing to the sale of a placebo I am, on the one hand, satisfying the desire of patients to "treat" their symptoms while, on the other, being available to determine the severity of the presented symptoms and refer where appropriate.

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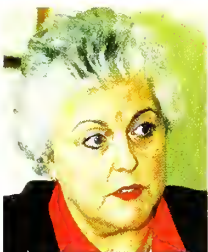
Since January last year, an emergency contraceptive Pill (Levonelle®) has been available to purchase from the pharmacy without a prescription. (The same formulation is available on prescription as Levonelle®-2.)

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The Royal Pharmaceutical Society's programme of new work on modernisation will cost £1.5 million. But what's wrong with the way the profession is regulated now? Christine Glover, who sits on the Society's modernisation steering group, explains

Brave new world

pharmacy in a
new age

The Royal Pharmaceutical Society is proud of its record as the organisation that regulates and leads the pharmacy profession. But our powers are largely based on law that is 50 years old and, for several years, we have been concerned that they are not adequate for a modern environment.

We have asked successive governments to help us bring our powers up to date. However, it is always difficult to obtain parliamentary time. In 1997, we were grateful when the late Sir Michael Shersby steered a Private Member's Bill through Parliament to create the statutory basis on which to deal with pharmacists who are unfit to practise through ill health. Since then, we have been waiting for regulations to allow us to implement this, which we now expect later this year.

In 1999, the Health Act made it possible for health regulatory bodies to amend their powers by Order in Council, a much quicker route than through full primary legislation.

We are now working with the Department of Health to bring forward an Order later this year, which we hope will pave the way for mandatory CPD and

long-awaited improvements to our disciplinary powers.

Over the years, the relationship between the public and health professionals has changed. People are better informed about their healthcare, expect a say in how they are treated and are no longer prepared to take everything on trust. As a result, there has been closer scrutiny of the safeguards that are in place to protect the public from harm, including the way that health professions are regulated.

Most recently, the Kennedy inquiry into children's cardiac surgery at Bristol Royal Infirmary has crystallised the view that health professional regulation has to include far more than just disciplinary machinery.

Regulation is now interpreted as an integrated set of processes that combine to assure the public of the competence and fitness to practise of the professional and to protect patients from harm.

This includes controlled entry into a profession, education, registration, setting and enforcing professional standards, promoting good practice, training, CPD, assessing competence, revalidation, dealing with poor performance, dealing with misconduct and

removing the right to practice.

Patient organisations have signed up to this new, broader definition. It opens up whole new areas of work for some regulators and new structures and ways of working for all. The Government has shown itself determined to bring all health professional regulators into line with the new thinking and is not prepared to tolerate old ways of working.

It is replacing the regulatory bodies for nurses and professions allied to medicine with new structures of its own design. It has been robust and explicit with the medical profession's regulatory body about the changes it needs to bring in.

Currently passing through Parliament is a Bill to establish a new, supreme regulatory body which will have the powers to step in and act where a regulatory body is seen to be failing.

What do these new developments mean for the RPSGB? Basically, it means a review of all aspects of how the Society supports pharmacists to create an organisation that is fit for modern purpose. The good thing is that, unlike some other regulators, the Society is already doing many of the things now required.

Details of what the Society still has to do have been published and can be found on its website.

Education and CPD have always been a crucial component of being a professional. Now we need to ensure that we deal with them in a way that equips pharmacists for the future. We will need to create a register-based on competence and evidence of keeping up-to-date.

Our approaches to standard setting and ensuring that standards are met must be updated and strengthened. We will need the appropriate mechanisms to deal with failures in performance and conduct.

The organisation itself will need to change, with structures that create opportunities to reflect devolution and to involve members of the public in our work. We will need to ensure that our work is open and transparent: modern regulators must be accountable and be seen to be so.

This is the first in an occasional series which will address issues arising from the Royal Pharmaceutical Society's modernisation programme.

Next: is the Society still going to be a membership organisation?

If the price is right...

US drug companies are seeking ways to make their prices more politically acceptable, explains New York pharmacy consultant **Tony de Nicola**

The significant and controversial issues which dominated the closing months of 2001 continue to have an impact on pharmacists throughout the United States in the early days of 2002.

The cost of branded medicines is still a headline concern, and since last autumn another large multinational company, Pfizer, has announced a discount plan targeted at uninsured senior citizens.

This plan is structured differently to the GlaxoSmithKline and Novartis plans, which call for a 25 per cent discount off the wholesale price for any of their products which are bought by eligible low-income seniors.

Pfizer's plan charges them a flat fee of \$15 for a month's supply of any Pfizer products which are on a list of certain maintenance drugs.

While the pricing structure may be different from the other two plans, the good news for pharmacists is that these discounts and lower prices will not significantly erode the minimal

gross profits that pharmacists have been earning on these high priced products.

In fact, the plans may actually provide a benefit for community pharmacies – independents and multiples alike – as it will enable these low income seniors to seek pharmacy services in their local communities without worrying about price differentials that have been available via mail order pharmacies or over the internet.

That said, a new concern has arisen about the plans, which many expect to be copied by a number of other major branded manufacturers in the first quarter of this year. The registration procedure and administration of these programmes is different in each case.

So far, one major pharmacy benefits manager (PBM), Express Scripts, and one large wholesaler, McKesson, have been appointed as administrators for different plans. No doubt other large PBMs and processing entities will compete for this business and

become involved as other major manufacturers launch these programmes as a way to fend off government pressure to lower their prices.

Pharmacists are becoming concerned about the complexity of submitting claims. They fear the way in which they will be reimbursed for discounts given at store level will become unwieldy and difficult to administer.

Additionally, there may be a time lag between the dispensing of the product and the collection of the "discounted amount" that is not charged to the patient and must be reimbursed to the pharmacist by the manufacturer.

This has led to a new initiative, sponsored by two large retailer trade groups (National Association of Chain Drug Stores and National Community Pharmacists

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Association), which it is hoped will develop some sort of "standardised" way of handling the administration of these different plans. The aim is to ease pharmacists' paperwork burden and ensure that positive cash flow is maintained in the shrinking margin environment that exists in the USA today.

To further confuse the situation, CMS administrator Tom Scully,

the original architect of the controversial Government supported "Medicare Rx Card Plan", recently announced in more than one public venue that the Government has not given up on its idea of sponsoring a discount plan for uninsured seniors.

Mr Scully recently said that a reworked government plan would be announced shortly, since the original plan, launched last July,

was subsequently derailed by pharmacy trade organisations after a court action led to an injunction being granted in late 2001.

When, and if, the Bush administration does launch a plan for the 10 million uninsured seniors who are expected to meet the income levels required to participate, it will confuse the issue even more. It will undoubtedly add to the administrative burdens that US pharmacists already endure due to the multitude of different plans and PBMs who administer them.

In the meantime, the overall US prescription environment continues to grow at a record pace. High prices and insurance restrictions notwithstanding, US citizens are filling prescriptions at higher and higher rates. The prescription/drug component of our overall \$1.3 trillion (£920 billion) healthcare spend has never been higher and is growing at a faster rate than the overall rate of the entire environment.

Pharmacies are getting busier and busier, a good news/bad news scenario. While revenues continue to grow, margins continue to erode and there is no end in sight to the pharmacist (and now technician) shortage. This is leading to major

concerns about patient safety and the accuracy of prescription filling, a vexing and serious problem for all pharmacists and indeed for all healthcare practitioners.

To compound that situation, K-Mart, which operates more than 2,000 pharmacies, recently announced a Chapter 11 bankruptcy filing this week. The possibility of the chain closing some or all of its pharmacies at some point will spill even more prescriptions into other pharmacies, independents and multiples alike, making them even busier than they already are.

The only possible benefit that might be seen in this (at least to other pharmacy entities) would be the freeing up of K-Mart pharmacist employees, probably 4,000 or so.

But the overall impact of the failure of this \$40 billion business, the US's third largest retail entity, is a big negative for the economy which, like many others in the world, is struggling with the current recessionary environment. Shareholders, lenders and suppliers will all suffer the negative effects of a business failure of this magnitude.

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Becoming more involved in prescribing benefits everyone in the medicine supply chain, as *Tim Beard*, a prescribing support pharmacist, explains

Giving prescribing that extra edge

Prescribing support is yet another of the services that community pharmacists can offer. Pharmacists are well qualified and experienced and know that we could make a difference, at least initially. If only we could get our hands on the practice computer, we could show the surgery staff how to spot those elementary errors and inconsistencies.

Most of the improvements from simple interventions would make life easier in the pharmacy and many would benefit the patient. They might save some of the precious prescribing budget, if only by reducing waste. Things like items duplicated on the repeat request slip, medicines not taken for years and not removed from the list, 28 days of this and 56 days of that along with 100 tabs aspirin dispersible 75mg.

Think of the patient who has seven different items on the list, most of which are prescribed for three months, but has to go round the system every week because they all run out of phase and his wife has her Inderal prescription every month. Holidays are coming so it's better for him to order everything to be on the safe side. There is unnecessary waste, over-ordering, confusion and inconvenience.

Remember poor Albert's widow, the lady who brought back all those Losac 40mg capsules. He'd had those for years, she said, but he tried to do without them if he could. Kathleen was taking 5mg of lisinopril, but last time her blood pressure was up a little, so she was asked to double up to 10mg. Next time she needed a prescription, she asked for four packs instead of two – no problem; they're so helpful at the surgery. Here we



Continued on page 20 ►

“Pharmacies will usually benefit from increased generics... however, it is important that your interest is seen to be largely professional”

◀ Continued from page 19

start to get further into the realms of cost saving (while still facilitating compliance).

We all read those prescribing circulars from the health authority or PCT, which tell us (among other informative nuggets) why felodipine is recommended. It's strange, then, that we never dispense it. Surely most patients with angina should be on aspirin and why do they all seem to get Imdur? The repeat form says that a review was due six months ago. Who reviewed these drugs last time and why didn't they make changes then?

Now we are in the rarefied upland of formularies, disease registers and medication reviews. But we could still make a difference and we don't all have an MSc in clinical pharmacy.

It would be good to have the chance to put some of these things right, and if the local medical practice does not already have practical prescribing support from a pharmacist, there will be plenty of “low-hanging fruit” for you to pluck. Your intervention will apply the brake to prescribing expenditure.

Patients will benefit through thoughtful, rational prescribing and you will be able to solve directly more of their medication problems. Your intervention may reduce iatrogenic complications and side effects. It will probably make your life easier with fewer corrections and queries and will often result in more prescriptions. Your clinical knowledge will increase rapidly and your professional standing will be enhanced.

The generic prescribing rate is a good measure of how far a practice has got with quality prescribing and effective prescribing systems.

This is stated in the quarterly M.A.T. data. It is extremely difficult and probably

inappropriate to increase the proportion above 85 per cent. Anything over 70 per cent is reasonable. To increase and maintain the rate of generic prescribing, it is necessary to scrutinise repeat prescribing for individual patients and to achieve consensus between partners over how drugs are prescribed. This is a good base from which to address the more difficult issues of which drugs are prescribed and which prescriptions can be changed.

Pharmacies will usually benefit from increased generics, as margins are generally better on these drugs. However, it is important that your interest is seen to be largely professional and not commercial. This is probably best achieved by pointing out how everybody gains from rational prescribing.

This should not be another service that community pharmacists provide for nothing. In the past there have been no regular funds available for projects of this kind and much of the effort, which should have gone into the service, has gone into finding financial support. But times are changing and there are new opportunities in prospect.

Many practices are moving to a personal medical services contract and more will follow. PMS facilitates the provision of new services, and existing ones, as a package driven by an agreed protocol with defined objectives and measurable outcomes and indicators. A prescribing

support service could be incorporated into such negotiations, but it would probably need to be focused on cost savings, although prescribing aspects of the NSF targets could be incorporated.

If there is a clear cost-saving opportunity, it may be possible for a practice to negotiate with the PCT to top slice the prescribing budget to pay for any input. The PCG itself may have funds to direct towards practices with recognised prescribing issues. The advent of local pharmaceutical services (LPS) is likely to provide opportunities to bid for funds to provide such a service and may offer scope for reorganising the pharmacy workload to allocate protected time to it.

The movement of the workforce from community pharmacy into practice-based services is having a measurable effect on the availability of locums at a time of acute shortage of pharmacists.

However, changes taking place in the Health Service in general and in pharmacy in particular provide opportunities which are greatest for those who recognise

them and act early in the process.

The greatest barrier to pharmacist input into local prescribing is professional sensitivity and lack of understanding. Some GPs will be suspicious of your motives, others will be reluctant to expose themselves to what they expect will be criticism and some will doubt that you have the necessary skills. They may feel they will have to pay for a service that they should be able to provide for themselves.

If your local practice is forward-thinking and innovative, and the partners can readily agree on what should be done and are keen to hear your ideas and debate the issues, it is likely that their prescribing will be less urgently in need of your attention than some other practices. This is not to say that they don't need you at all, but that your interventions will be more sophisticated and you will need to have the latest evidence at your fingertips. The greatest challenges lie with those more reluctant to change and you will need to approach them with caution and be patient.

There is no reason why you cannot offer your services to dispensing practices if you can retain your objectivity, resist the urge to criticise and understand that their prescribing is already more rational than most.

Keep it simple initially and aspire to greater things. Most practices have protected education time for all staff members (such as QUEST sessions). You may be able to attend some of these sessions, when you can research the format and frequency. Find out when they are planning future meetings and offer your services. A practice on the ball will have access to sponsorship for these sessions. If not, there is a further opportunity for you to demonstrate your skills.

Practices are often looking for sessions that can be adapted for receptionists and managers as well as clinical staff. Offer a meeting along the lines of “Limiting waste in the NHS”; collect all the returns to the pharmacy over a month and do some calculations, estimations and extrapolations. Stimulate a discussion on how this waste comes about and produce a long list of reasons and what might be done about it. With a little skill and careful preparation, you will lead the group to the inevitable conclusion that what is

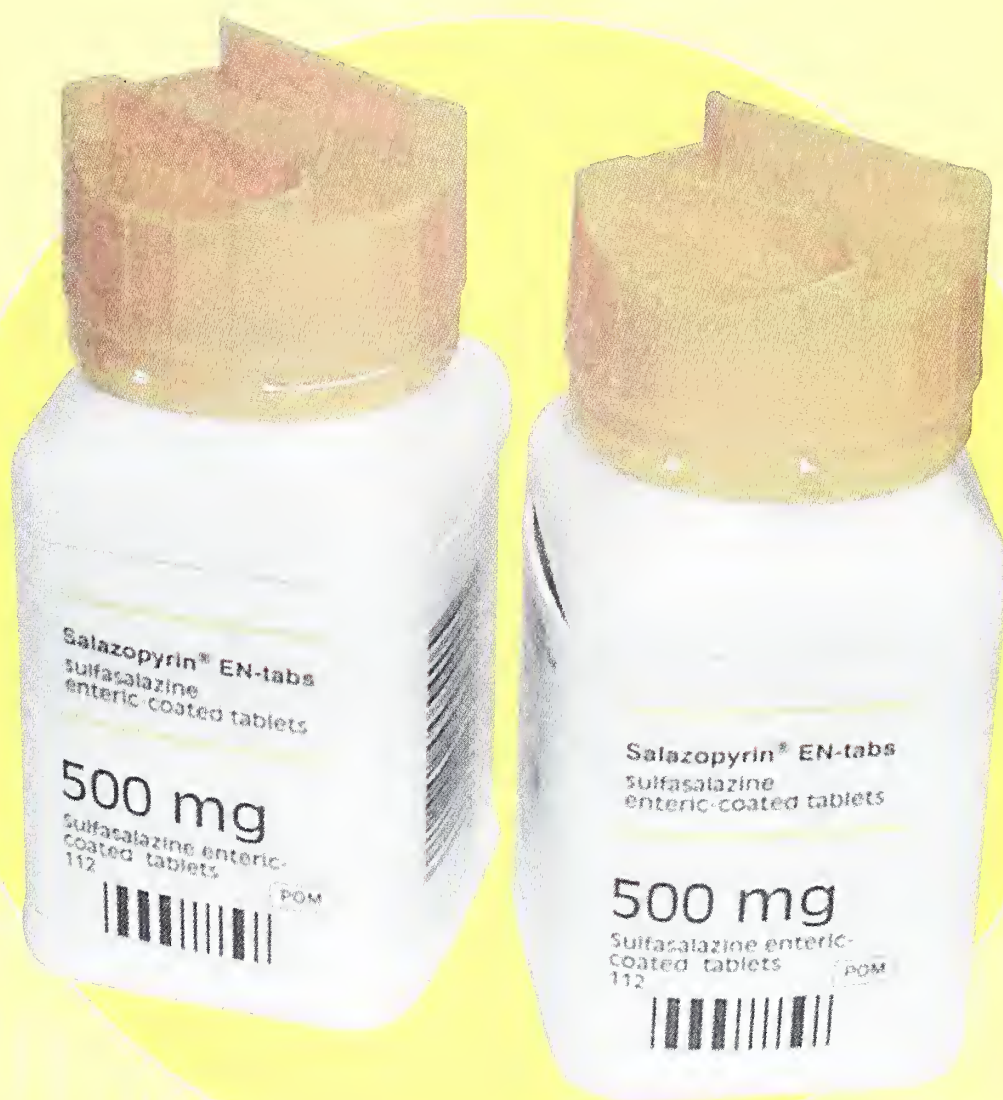
Continued on page 22 ▶

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◀ Continued from page 20

“There is no reason why you cannot offer your services to dispensing practices if you can retain your objectivity”

needed is someone to sort out their prescribing and to educate and inform their patients.

All this can be worked up to a two to three hour session with discussion groups and feedback sessions. You can provide lunch via the felodipine (or lansoprazole) representative who will also cover your locum expenses. If all this is a little daunting, scale it down to a lunchtime clinical meeting with those partners most likely to initiate change.

Talk to your PCT prescribing advisor who will already have a view of the priorities for change within your chosen practice and ensure that they support your objectives. The practice may already have some sessional input from a pharmacist, but this does not preclude your involvement. Work with him or her to identify priorities, highlight target groups of patients or individuals and establish a role in identifying problems and informing patients about relevant changes. Talk to the other pharmacy managers in your area.

Another barrier to uptake of your service is the doctors' perception that they must be utterly impartial in their dealings with the local pharmacies, so a strategy that has the support (or lack of objection) of interested parties is more likely to succeed. I believe that many of the changes in prospect for pharmacy will demand co-operation between existing contractors (electronic transfer of prescriptions, LPS, collaborative medicines management projects) so you may as well start now if you haven't done so already.

Your input will involve identifying a need for change, agreeing what that change should be and making it, or causing it to be made. An objective must first be identified and clearly stated. The objective may be simple, such as medication review for a

specified group of patients, or broadly based, such as saving money.

It is essential to keep the objective in mind. Prescribing reviews may result in more expenditure. Promises of significant savings can be undone by such events as unexpected generic price fluctuations. Perhaps the most appropriate objective is one that encompasses evidence-based medicine, cost-effectiveness and waste limitation and avoids making promises that cannot be delivered. Prescribing for a specified group of patients should be put, as far as possible, beyond reproach.

Your role will complement that of the PCT adviser as you will implement the policy and do the work, rather than just present the evidence and facilitate agreement. There are essentially two ways of providing this practical

prescribing support – proactively and reactively. The recognised approach is the proactive one where decisions are made about what will be prescribed, and the resulting policy implemented.

A reactive approach may be useful for a community pharmacist, at least initially to sell the service, or to implement a relatively modest scale of change. Prescriptions pass before you in significant numbers each day and are scrutinised.

Potential alterations can be highlighted at this point (change to generic, change quantities, remove redundant item, change to more appropriate alternative etc). Your recommendations should be recorded and communicated to the surgery. The patient can be counselled at this stage if the intervention is of a previously approved type. Data on potential interventions could be collected, analysed and presented to the practice as above to begin discussions on the sort of service you could provide.

You must identify the prescribing needs of the practice by agreement with the partners. You must also agree a plan of action with realistic and measurable outcomes that can be achieved in a specified time. Write this into a contract that will also address confidentiality issues. Do not underestimate the amount of time that even modest changes require. Do not be distracted from what has been agreed; it is easy to become the practice “sweeper” for all problems that the administration staff cannot solve when clinical staff are unavailable.

Remember that you will probably be required to write a report on what you have done. Don't sell yourself cheaply and don't link your service to specific cost savings. Be tactful and do your homework. If you are successful, you will begin to appreciate what all those years of training were for and you will have done your bit to enhance the standing of the profession with our primary care colleagues and with their political masters.

● *Tim Beard is prescribing support pharmacist at Goyt Valley Medical Practice, Whaley Bridge, High Peak. He has a PhD in pharmaceuticals and a Diploma in Prescribing Science, and has also worked in hospital pharmacy and the pharmaceutical industry*

NEOCLARITYN TABLETS

ABBREVIATED PRESCRIBING INFORMATION

Neoclarityn (desloratadine) 5 mg film-coated tablets. **Uses:** Neoclarityn is indicated in adults and adolescents for the relief of symptoms associated with seasonal allergic rhinitis and chronic idiopathic urticaria. **Dosage:** Adults and children 12 years and over: One 5mg tablet, once daily. **Contra-indications, Precautions:** Hypersensitivity to desloratadine, loratadine or its metabolites. Efficacy and safety of Neoclarityn have not been established in children under 12 years of age. Neoclarityn should be used with caution in patients with severe renal insufficiency. Neoclarityn does not potentiate the performance-impairing effects of alcohol. No clinically relevant interactions were observed in clinical trials in which erythromycin or ketoconazole were co-administered; however, some interaction with other drugs cannot be fully excluded. The safety of Neoclarityn during pregnancy has not been established. Neoclarityn should not be used during pregnancy unless the potential benefits outweigh the risks.

Desloratadine is excreted into breast milk, therefore the use of Neoclarityn is not recommended in breast-feeding women. Neoclarityn has no or negligible influence on the ability to drive and operate machines. **Side-effects:**

At the recommended dose of 5 mg daily, undesirable side-effects with Neoclarityn were in excess of those reported with placebo were observed in 4% of patients. The frequency of adverse effects in excess of placebo is:

Headache (1.2 %)
Nausea (0.8 %)
Dizziness (0.6 %)

Overdose: In the event of overdose, consider standard measures to remove unabsorbed active substance. Symptomatic and supportive treatment is recommended. No clinically relevant effects were observed following administration of up to 15 mg of desloratadine (9 times the clinical dose). Desloratadine is not eliminated by haemodialysis; it is not known if it is eliminated by peritoneal dialysis. **Presentation:** Neoclarityn is supplied in unit dose blisters comprised of transparent blister film with foil lidding. Packs of 30 tablets. **Basic NHS Price:** £7.57. **Marketing Authorisation Numbers:** EU/1/00/161/011, 30 tablets. **Legal Category:** Prescription only. Further information available from Schering-Plough Ltd, Kenilworth Park, Welwyn Garden City, Herts., AL7 1TW. **Date of revision of text:** August 2001.

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Date of preparation: January 2002. NCL/02-197

NATURAL SELECTION



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NEOCLARITYNTM

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www.neoclarityn.co.uk

Antidepressant data is flawed, says CA

Patients are not being given full information on the efficacy and safety of antidepressants, says the Consumers Association.

An article in the latest edition of *Health Watch* claims the effectiveness of the drugs has been exaggerated while their unwanted effects, including the risk of withdrawal problems and a possible risk of increased suicidal behaviour, are underplayed.

Although the authors of the article acknowledge that antidepressants do work in some cases, they say that claims produced by the Royal College of

Psychiatrists and the Depression Alliance that 60-70 per cent of patients will get better within a few weeks of treatment is incorrect.

Withdrawal reactions when patients stop selective-serotonin reuptake inhibitors are also not explained to patients properly, the article claims.

The Medicines Control Agency says that SSRIs are known to cause withdrawal reactions, but the RCP advice says "there is no evidence that antidepressant drugs cause dependence".

However, the USA's Food and

Drug Administration has recently advised GlaxoSmithKline that the warnings for Seroquel should be amended to warn people of physical dependency (*C&D*, February 2, p29).

Over 22 million prescriptions were written for antidepressants in England in 2000 compared to nine million in 1991. Over the same period the cost to the NHS of these prescriptions increased from £54 million to £310m.

For more information:
www.which.net

MRSA worst in London hospitals

London hospitals have the highest rates of methicillin resistant *Staphylococcus aureus* infections, while rates in the North West are the lowest.

But higher rates do not necessarily indicate an infection control problem, as the incidence could depend on the numbers of vulnerable patients and the high risk procedures being carried out.

A report published by the Public Health Laboratory Service shows that the number of cases of MRSA bloodstream infection in acute trusts ranges from 0 to 0.69 cases per 1,000 days spent in hospital (occupied bed days).

The report is the first to be published since the Department of Health set up a compulsory MRSA surveillance scheme in April 2001. The Health Minister Lord Hunt has welcomed the report as it will enable improvements in hospital infection control to be assessed in the future.

For more information:
www.phls.co.uk/publications/CDR%20Weekly/index.html

Exercise and diet best at preventing diabetes

Lifestyle changes are more important in reducing the incidence of diabetes in people at high risk of the disease than treatment with metformin, a new study has found.

More than 3,200 patients at risk of diabetes (those with an elevated fasting plasma glucose concentration and post-load plasma glucose concentration, overweight and with a sedentary lifestyle) were randomised to receive a lifestyle-modification programme or metformin, 850mg twice daily.

The lifestyle programme had

goals of a 7 per cent weight loss and at least 150 minutes of physical activity weekly.

Metformin reduced the incidence of diabetes by 31 per cent while lifestyle changes reduced the incidence by 58 per cent when compared to placebo, after an average follow-up period of 2.8 years. Effects were similar in men, women and all racial and ethnic groups. The study appeared in the *New England Journal of Medicine*.

For more information:
www.nejm.org
NEJM, 2002; 346:393-401



Keeping active is one of the surest ways of staying diabetes-free

Only some women are benefiting from HRT

Combined hormone replacement therapy has not been shown to be generally beneficial for the quality of life of post-menopausal women, according to a study in the *Journal of the American Medical Association*.

Results from the Heart and Estrogen/Progestin Replacement Study (HERS) showed that HRT only improves quality of life for women with menopausal symptoms.

In a randomised, placebo-controlled, double-blind trial of 763 women with heart disease, 363 received 0.625mg of conjugated equine oestrogen with 2.5mg of medroxyprogesterone



HRT has not been shown to be beneficial for the quality of life of post-menopausal women

acetate daily and half placebo, for three years.

Over three years patient scores for physical function, mental health and energy declined in both groups but depressive symptoms were little changed.

The effect of HRT on these measures depended on whether the women had "flushing" symptoms at entry to the study. Women suffering from flushing showed improved mental health over follow-up compared to those on placebo.

For more information:
www.jama.ama-assn.org
JAMA 2002; Vol.287 No 5

Antibiotics may lead to asthma

Children who have had more than four courses of antibiotics in the first year of life are at twice the risk of developing asthma, according to a new study.

Contrary to previous suggestions that the rise in the prevalence of allergic disease is due to a decrease in exposure to infections, this study, in the *The Journal of Allergy and Clinical Immunology*, found no evidence that exposure to infections reduced the incidence of allergic disease.

The birth cohort study of more than 29,000 children was carried out using the West Midlands section of the UK General Practice Research Database.

NOTICE

Nutritionals offer the Best Commercial Opportunity to Independent Pharmacies...

Trading conditions for the independent pharmacy have never been more competitive than today. The commercial thrust and financial resource presented by the large chains and major supermarkets exert a continuous pressure on the ability of the independent pharmacy to remain viable.

The situation has clearly been exacerbated with the abolition of retail price maintenance for OTC medicines.

In addition, the standard pharmacy lines of toiletries, cosmetics, baby products etc offer very little in competitive advantage, or any real opportunity to combine a reasonable margin with realistic volume.

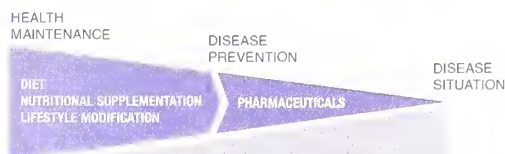
Hence, the independent pharmacy is still left with prescription medicines as the only opportunity for combining serviceable market demand with real profitability.

The opportunity for nutritional products

There is, however, one product area that the independent pharmacy is in a unique position to exploit which will generate good profitability and where a serviceable market is easily reached...**nutritional supplements!**

And there are two very good reasons why the independent pharmacist is in such a unique position with regard to sales of nutritional supplements:

1. Nutritional supplements inherently have their emphasis of effect on the maintenance of health and prevention of disease, whereas with pharmaceuticals, the emphasis is on therapeutic application of a disease situation. Hence, the two approaches go hand-in-hand and are complementary and logical from both a scientific viewpoint and from the point of providing an encompassing approach to primary healthcare.



2. The pharmacist, as a trained scientist, has a fundamental knowledge of human physiology and its interaction with maintenance of health. By using this understanding to provide sound advice on the benefits of good diet and the judicious use of nutritional supplements, the pharmacist is in a unique position in the retail environment. Moreover, by associating this knowledge and advice with a high quality, own-brand range of nutraceuticals, the independent pharmacist can produce a sustainable and highly profitable business activity.

What's more, our comprehensive technical and sales services have been specifically developed to support you every step of the way in the establishment of your own brand and its progression into a sustainable and profitable business area for your pharmacy.

...as a result of this...

Working with Bellwether on your Own Brand offers an exciting and highly profitable new dimension to your business. Run through the checklist below:

- ☒ Highest quality raw materials and packaging
- ☒ Products manufactured under strict ISO9001 conditions
- ☒ Exciting, high-specification product range
- ☒ Customer information leaflets for every product on the range
- ☒ Wide choice of labels designs
- ☒ Your own details and logo on your choice of label
- ☒ Low minimum order
- ☒ Competitive pricing providing you with excellent margin



Want to know more?
Phone Laura on
01639 813 555

Scriptlines

Cozaar 100mg launched

MSD launched Cozaar (losartan) 100mg tablets on February 5.

The higher strength tablet is designed to treat high-risk hypertensive patients including those with type 2 diabetes and nephropathy.

Colour coding is being introduced on the Cozaar packaging, to help distinguish between doses.

Price: £22

Pack size: 28 tablets

Pip code: 284-9081

MSD

Tel: 01992 467272.

Sno Phenicol discontinued

Chauvin has announced that Sno Phenicol (chloramphenicol) eye drops will be discontinued from April 1, due to commercial reasons.

For more information:

Chauvin Pharmaceuticals

Tel: 01708 383838.

Frontshop

Take advantage of baby products from Vantage

Vantage is launching a range of baby care products as the first in a collection of own-brand goods to hit the market by the symbol group this year.

The products have been introduced, says AAH Pharmaceuticals, to provide customers with a good-quality, low-cost alternative to branded products, while offering pharmacies an attractive alternative source of revenue with a significant profit margin.

The five baby products are baby bath, lotion, oil, powder and shampoo, each with a unique formula developed for Vantage. The company says the products provide "a complete, gentle and dermatologically-tested selection of cleaning products for even the most sensitive baby".

Each product is in a different



coloured pack, making it easy to pick out on the shelf, while label designs are fun, with clear typography. Each has a different animal cartoon on the front and each product retails at £1.09.

The products are available only to Vantage members and can be ordered via AAH-Point or Link.

For more information:

AAH Pharmaceuticals Ltd

Tel: 024 7643 2000.

Join UniChem Brand Club



RECOMMENDED FOR QUALITY AND VALUE

UniChem Cold Remed

£1.85 UniChem Flu Strength Powders (5's)

£1.49 UniChem Cold Relief Capsules (16's)

£1.99 UniChem Hot Lemon Powders (10's)

Contains Paracetamol

Always read the label

UniChem aims to help pharmacists capitalise on consumer demand for own-label products with the launch of the UniChem Brand Club.

Pharmacists who sign up to the club will receive monthly promotional packs of seasonal and best selling products at a discount of up to 30 per cent. They will also receive merchandising material and product training material aimed at pharmacy assistants.

There are more than 500 products in the UniChem range, 35 of which feature in the company's top 250 OTC sellers.

To join the UniChem Brand Club,

pharmacists sign up through their pharmacy development manager and receive a welcome pack, as well as the automatic monthly offers.

Following the success of its "post-RPM" initiative, in which the company sent a free product pack to all customers, UniChem has sent out a "Cough Cold" pack worth £30 at retail prices to every independent customer.

The pack contains a wide range of winter remedies and best sellers.

For more information:

UniChem Ltd

Tel: 020 8391 2323.

Cough, cold & flu FORECAST



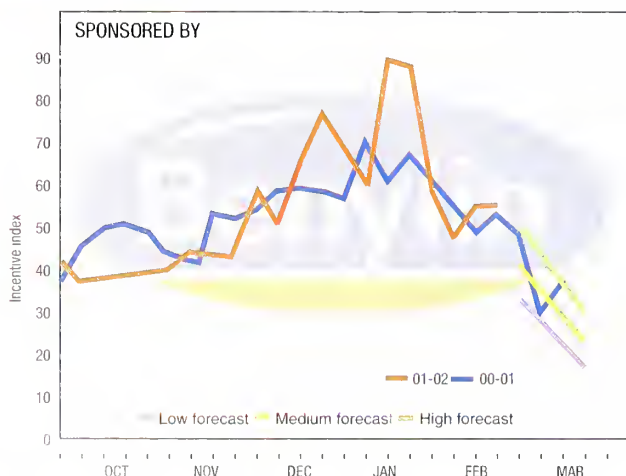
KEY FACTS

- Glasgow, Birmingham, Norwich and Bristol have stepped down onto Advisory status
- Leeds, Manchester and London remain on Alert status
- Coughing is the most prevalent symptom

Information updated weekly by SDI

◆ Continue on Alert ◆ Advisory

Benylin



Strefen lozenges to go P

Crookes Healthcare will launch Strefen flurbiprofen 8.75mg lozenges as a P product later this year. They will be foil blister-packed in a carton.

The launch, which will be in time for the winter cold and flu season, introduces the NSAID flurbiprofen

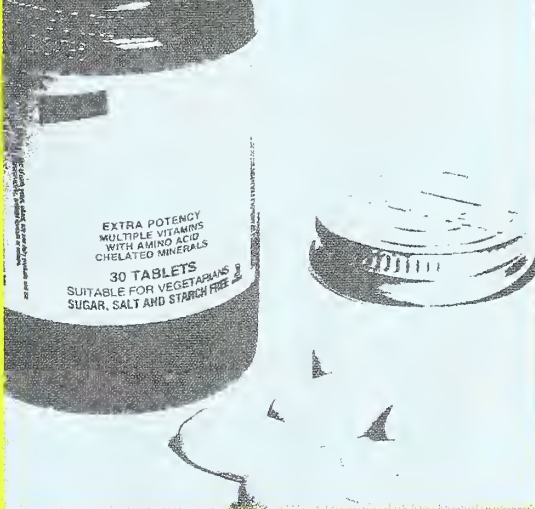
into the OTC sore throat arena.

Pharmacists will not be able to order Strefen as a P product until later in the year, but the POM product is available.

For more information:

Crookes Healthcare

Tel: 0115 953 9922.



Natural Products Europe

2002



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instant online registration: www.naturalproducts.co.uk fax: 01903 817317
please quote ref: cad

Scriptlines

Once-daily HIV infection drug



Gilead Sciences has launched Viread (tenofovir disoproxil fumarate), an anti-retroviral agent for HIV infection in patients who are experiencing early virological failure.

Viread tablets, 245mg, are licensed for the treatment of patients over 18 in combination with other anti-retroviral agents. The recommended dose is one tablet daily with food.

Price: £255

Pack size: 30
Pip code: 282-3698
Gilead Sciences
Tel: 01223 571400.

Yellow fever vaccine launched

Aventis Pasteur has launched Stamaril, a live attenuated yellow fever vaccine.

It is licensed for use in adults and children aged nine months and over. It is only available through a registered yellow fever centre, as designated by the Department of Health.

Protection starts seven to 10 days after vaccination. The yellow fever international certificate of vaccination is valid 10 days from the date of vaccination for 10 years.

For more information:

Aventis Pasteur MSD
Tel: 01628 785291.

Silicone borders for Mepilex

Molnlycke has introduced a bordered version of its Mepilex dressing.

Available in four sizes, the dressing has a soft silicone border which allows it to remain in place without the use of secondary fixation.

Price: 7.5cm² £6.40, 10cm² £11.60, 15cm x 20cm £23.75, 15cm² £18.95

Pack size: five dressings per pack
Pip code: see Price List Supplement
Molnlycke Health Care
Tel: 1582 677400.

Frontshop

Don't forget your pills, mate!

The PillMate Pharmacy Pack from Shantys Ltd offers pharmacists the chance to make more than 43 per cent profit on return.

The pack contains the five most popular items from the PillMate range – the Large 7 Day, offering seven compartments with flip-top lids; the Twice Daily, which can store seven days of twice-daily medication or two weeks once-daily; the Large Multi-Dose Weekly which can take one week's medication taken up to four times daily; the Day Out to allow consumers to carry one day's medication when away from home; and the PillCutter which splits tablets in two for easier swallowing.

The pharmacy pack comprises a box of 36 Day Out PillMates and a tray containing four each of other



products. Individual items range in from £0.99 to £3.99 and pharmacists ordering the pack will also receive two free bottles of NitLotion based on natural ingredients (rsp £6.99).

PillMate products have solid,



translucent or transparent lids and come in four colours, making it easier to separate the medication for individuals within

a family or group. Where possible, the products also have markings in Braille.

For more information:

Shantys Ltd
Tel: 020 8595 7836
www.shantys.com



'Travel' free for first 200

Healthcare Innovations is offering free sample packs of its TravelBac and TravelGinger supplements free to the first 200 retailers to apply.

The free stock – two packs of each product – is worth £24.

TravelBac is a probiotic supplement containing seven different strains of "friendly" bacteria and vitamin B complex and is designed to act as a barrier against the infective bacteria which cause common stomach and gut problems.

TravelGinger is formulated to relieve the symptoms of travel discomfort in children and adults. It contains organic ginger root and a combination of vitamins C, B3, B6 and K. Both products are in packs of 30 capsules, retailing at £5.99.

For more information:

Healthcare Innovations
Tel: 020 8361 7937.

Kids-Zone goes back to the Ice Age

The Kids-Zone children's toiletries from MPM Consumer Products are part of a major promotion for the Twentieth Century Fox film Ice Age to be released next month.

MPM has been chosen as an official promotional partner for the film and has developed special packaging and a limited edition gift set with an on-pack competition offering the chance to win a family holiday to Iceland.

The themed packaging, which features the main characters from the animated film, will be available throughout the year.

MPM sales director Steve

Roberts said: "For our trade customers, this initiative gives added impetus to the Kids-Zone range and should help maximise both impulse and planned purchases."

Details and an entry form for the competition, which also offers 100 prizes of Ice Age goodie bags for runners-up, are on a detachable back label on the promotional packs and also on the goodie bag, which includes shampoo, limited edition bath foam and two exclusive lip balms.

For more information:

MPM Consumer Products
Tel: 0161 231 6111.

Pharmacy first for condoms

More than half of all condom users in Britain see the pharmacy as their main source of purchase, says the 2002 Durex Report.

The report reveals that condoms remain the most popular form of contraception for Britons, especially with men aged 16-24, 65 per cent of whom choose them ahead of any other method.

More than 80 per cent believe that women who carry condoms are sensible and responsible, with only five per cent

seeing them as promiscuous.

Worryingly, 43 per cent of Britons are taking no steps to protect themselves from HIV/AIDS and other sexually transmitted infections in spite of the fact that more than a quarter say HIV/AIDS is their greatest fear and one third know someone who has had a sexually transmitted infection.

For more information:

SSL International plc
Tel: 0161 654 3000.

Eumovate's 'in charge' on TV

GlaxoSmithKline is promoting Eumovate Eczema and Dermatitis Cream to consumers for the first time with TV and press advertising.

A 30-second TV advert is on screen until the end of the month and shows a professional woman in her late 20s, who is suffering the persistent itch, characterising a skin flare-up with a voice in her head saying "Scratch me... just another little scratch". She uses Eumovate Eczema and Dermatitis Cream and, a few days

later, is seen sitting in a café with no sign of a problem. The adverts tell consumers to ask their pharmacist for further advice.

A press campaign, in titles including *Prima*, *Woman*, *Best*, *Top Santé*, *She* and *Essentials*, has the strapline "show skin flare-ups who's in charge".

For more information:

Pip code: 281-9142

GlaxoSmithKline Consumer

Healthcare UK

Tel: 020 8560 5151.

TVnext week

Bassett's Soft & Chewy Vitamins: GMTV, C5, Sat

Blistex: GMTV

Clearblue Pregnancy Test Kit: All areas + C5 except GTV, U, CTV, C4, W

Eumovate: B, G, Y, HTV, TT

Fybogel: GMTV, Sat

Gaviscon Tablets: All areas

Haliborange: GMTV

Imodium: All areas

Kalms: GMTV, Sat, C5

Lucozade Sport: All areas except U, CTV, C4, GMTV

Neutrastate: G, Y, A, M, LWT, TT, C4

NiQuitin CQ: All areas except U, CTV, W

Nivea Hand Age Defying Crème Q10: All areas

Nivea Soft: All areas except C5, Sat

Nyctol Herbal: All areas

Olbas: C5, Sat

Pearl Drops: All areas + C4, C5, Sat

Senokot: All areas

Sensodyne Gentle Whitening: All areas except U, CTV

Sensodyne Total Care: All areas except U, CTV

Seven Seas Cod Liver Oil: G, Y, A, M, LWT, TT, C4

Throaties Pastilles: GMTV

Venos: GMTV

Wella Vitality: All areas

Wilkinson Sword 3D Diamond: GTV, STV, B,G,Y,A,W,TT, C4,C5,Sat

Zovirax: C4, C5, Sat

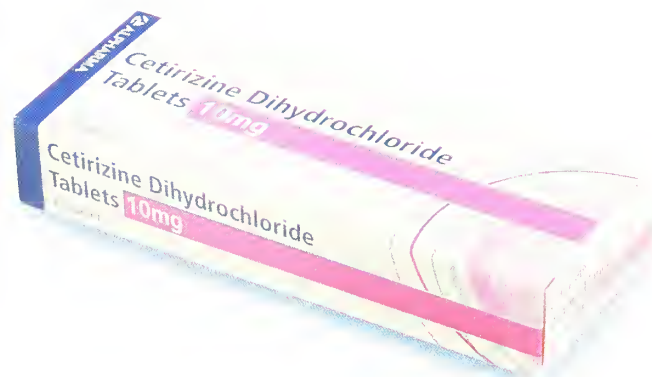
PharmaSite for next week: Zovirax & Thornton & Ross Care Range – Window, Midrid – In-store, Thornton & Ross Care Range – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire



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A poor running or walking style can damage the feet and even lead to back, leg or hip injuries.

Sarah Purcell looks at how sport can affect our feet



When we run, our body weight is multiplied by up to three times, and our feet bear the brunt of the impact – with around 1,000 strides for each foot for every mile we run. An average 11 stone man will process 112 tonnes of weight through each foot for every mile he runs. And if you are a footballer, every time you kick the ball the compression force on your toes is equivalent to five times your body weight. Your feet have two essential functions – to absorb impact when they hit the ground and to act as a lever that propels your body forward. Because of this they are subject to more pressure and higher risk of injury than any other part of our body.

“All too often when people take up a new sport or exercise they try to do too much, too soon, without adequate preparation. And when they do experience pain or an injury, they don’t take time out to recover, but carry on and often make things worse,” says chartered physiotherapist Michael Garmston, physiotherapist to the Olympic athletics team and lecturer at Birmingham University. “I would advise anyone taking up a new sport, or who’s having problems, to get a biomechanical assessment done to prevent foot and other injuries occurring.”

An adult has 26 bones and 19 muscles in each foot, inter-

connected at 30 joints. The foot can be divided into three sections: the back part, or heel, comprises the ankle bone (talus) and heel bone (calcaneus), the two largest bones in the foot; the middle part comprises a series of smaller bones that fit together like a jigsaw, which attach to the metatarsals, forming the front part of the foot; the metatarsals are connected to the phalanges, which form the toes. The big toe has two phalanges and all the others have three.

Tendons that pass around the ankle connect the muscles that act on the bones of the foot and toes. The main blood vessels and nerves pass in front of and behind the inside of the ankle joint to supply the foot.

The bones in each foot form an arch along the inside from the heel bone to the big toe, and another across the top of the foot. These are held in shape by ligaments and muscles. Their job is to give flexibility to the foot when we run or walk.

“The majority of foot injuries – and many other sports injuries –

can be linked to a problem with the mechanics of the foot – the way that a person walks and runs,” says Mr Garmston.

The most common mechanical problems are over-pronating (flat footedness), or keeping the foot in the flat position for too long, or over-supination, when you put too much weight on the outside edge of your foot. This tends to happen if you have a high arched foot.

The easiest way to find out if you over-pronate or over-supinate is to carry out this simple test. Dip a bare foot in water and make a foot print on a smooth surface sprinkled with talc. “In a normal foot, about a third of the foot area is in contact with the ground. If you over-pronate, you’ll see more of the foot touching the ground and if you over-supinate, then less than a third will be in contact with the ground,” says Trevor Prior, consultant podiatrist at City & Hackney podiatry and chiropody services.

“The most common reasons for over-pronation are a structural misalignment, which can be corrected with orthotics and the right shoes; tight calf or hamstring muscles, which can be helped with stretching exercises; and a core stability problem arising from the hips, which can be eased with exercises.”

The common causes of over-

supination include a structural problem or a muscle imbalance. “Over-supination is slightly harder to treat because the foot is less flexible, but orthotics and exercises will help,” says Mr Prior.

A biomechanical assessment will examine the way you walk and use your feet, and this will show the podiatrist the injuries from which you are most at risk. If problems are picked up, an orthotic support can help. This is a tailor-made insert which is moulded to the shape of your foot. Worn inside your shoes, it holds the bones in the correct position and distributes the body weight more evenly across the foot, so helping to minimise injuries.

The biomechanical assessment involves careful analysis of your feet and posture. “We’ll do a gait analysis, which involves taking video of the patient walking and running, and also put sensory insoles into the shoes to record how the feet carry the body’s weight and how well they work together,” says Mr Prior. Your body structure as a whole will also be assessed.

State-registered chiropodists and podiatrists are trained in biomechanics and can carry out an assessment to find out if a biomechanical problem might be

“Often when people take up a new sport or exercise they do too much, too soon”

enthusiasts also tend to suffer from shin splints and knee problems, says Mr Garmston. Sudden twisting of the knee, or repeated impact, can cause a ligament sprain or inflammation of the joint lining (synovitis). These can be treated with physiotherapy and rest.

A bruised or black toe, caused by a blow, is a common injury among footballers and rugby players, and usually results in the loss of the nail. Muscle strains also occur frequently, most usually caused by inadequate warm-up and tired muscles. Toe fractures are another hazard, caused by kicking or being trodden on. Unless it's the big toe, rest is usually enough to heal a broken toe bone.

Athlete's foot is a fungal infection which thrives in warm, moist conditions and is often picked up around swimming pools and from changing room floors. It begins as an itchy, scaly rash between the toes and causes skin to crack and peel, then turn white, soggy and unpleasant smelling. Some 11 per cent of us can expect to experience it at some time.

"Sports enthusiasts tend to have a higher incidence because they often wear the same trainers each day without allowing them time to dry out properly," says Mr Prior. Other causes include not drying feet properly, and synthetic socks.

Treatment

- Dead skin between the toes should be removed by rubbing with a soft towel. An anti-fungal treatment should then be applied.
- Recurrence can be prevented by dusting feet and hosiery daily with an anti-fungal powder.
- Wash feet and change hosiery daily.
- Wear flip-flops around swimming pools.
- Avoid synthetic hosiery which makes feet sweat.

Blisters

Around 5.2 million people suffer blisters every year, according to Scholl research, yet few of us know how to treat them correctly. They occur when the surface of the skin rubs against shoes or hosiery.

"The main cause of blisters among sports people is wearing shoes that don't fit properly – I'd guess around 90 per cent of us are wearing shoes that

life

are the cause of an injury or foot pain. This involves evaluating the way you walk and run, measuring angles and range of joint movements, and examining posture.

Loggers and runners

Achilles tendonitis is the most common injury sustained by these sports people, says Mr Garmston. Inflammation of the tendon is normally caused by over-use, poor technique or ill-fitting sports shoes. In the worst cases, the tendon can rupture when it is stretched violently. Physiotherapy is usually sufficient to treat tendonitis, though a ruptured tendon may need to be repaired with surgery.

Ankle injuries are also common, most usually caused by turning the foot over. A small fracture may go unnoticed, so it's important to have the ankle x-rayed to be sure in these cases.

Stress fractures such as shin splints are common among runners, especially novices. Pain in the shins is caused by overtraining the muscles that run down the front of the shin bone and are responsible for lifting the foot when we run. Common causes include shoes with insufficient shock absorbency, running long distances on tarmac and over-exercising.

Gym users and aerobics

Footcare product news

Australian Bodycare's **Foot Treatment** is designed to eliminate fungal infections such as athlete's foot as well as kill the bacteria that causes foot odour. It contains 5 per cent tea tree oil, which has natural anti-fungal properties, and can also be used to soothe tired, aching feet.



Wartner is the newest treatment for verrucas and warts. It works in a similar way to the liquid nitrogen treatment often used by GPs, freezing the verruca or wart. The aerosol treatment is applied to the verruca or wart and it should then fall off naturally within 10 days. It retails at £9.95 for 10 treatments. Passion for Life Products, tel: 01372-847272.

Legcare product news

Promogran is a new type of wound treatment from Johnson & Johnson which can be used to treat leg ulcers. Promogran is a protease modulating matrix of freeze-dried collagen and oxidised regenerated cellulose. In combination these compounds will inactivate the excess harmful proteases that can impede wound healing in leg ulcers. In a

controlled trial of 276 chronic leg ulcer patients, Promogran improved wound healing by 39 per cent in patients with ulcers less than six months old. The

treatment is applied directly to the wound and on contact with wound fluid or saline it turns into a gel that covers the wound

bed. It is available in two sizes. Johnson & Johnson, tel: 01344 871028.



Antistax, the red vine life supplement designed to relieve heavy, aching legs, is being supported this year with an extensive educational campaign.

It will target consumers in-store and with press advertising. Educational literature has been produced which will be available for pharmacists to hand out to customers. Boehringer Ingelheim, tel: 01344 741493.



Following continued concern about the risk of developing deep vein thrombosis during flying, Scholl has extended its Flight Socks range with the launch of a class 1 (14-17mmHg) compression sock range. The new class 1 sock is designed for people at a higher risk of developing a DVT. Available in three sizes, customers need to be measured to select the right size. They retail at £11.95 each.

Those at a higher risk of developing a DVT include anyone with a personal or family history of blood clots; over 40s; pregnant women or those who've recently given birth; women taking the contraceptive Pill or HRT; those with varicose veins; those who suffer from heart disease. SSL, tel: 0161 654 3000.



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'I have really recognised the need for effective alternatives to conventional OTC treatments'

Surinder Nath, Pharmacist at the Yardley Pharmacy in Birmingham completed the first module in December. He says: "Whilst studying I didn't really get the opportunity to learn about homeopathy, but since working in the community I have really recognised the need for effective alternatives to conventional OTC treatments, with more of my customers making enquiries about these products. Before I started the programme I had very little homeopathic knowledge and I didn't feel confident in making recommendations to my customers. Since completing the first module I have seen my confidence increase and I am beginning to put the things I have learnt into practice. What is especially rewarding is the feedback I receive from my customers when I have recommended a remedy which has proven to be effective. I am convinced that this will help me develop my business and look forward to completing the next module."

Homeopathy for pharmacists

Nelsons is offering pharmacists a learning package to bring their homeopathic counter-prescribing skills up to the mark

Nelsons, the UK's largest and Europe's oldest manufacturer of homeopathic medicines, has launched a series of four learning modules on homeopathy entitled 'Homeopathy for Pharmacists'. These modules carry the training seal from the National Pharmaceutical Association (NPA). The emphasis of the modules is to provide an introduction to the principles and practice of homeopathy and to provide pharmacists with the basic knowledge and confidence to undertake homeopathic counter-prescribing for some common conditions encountered in the pharmacy. The course comprises of four modules in total:

- **MODULE 1**
Background to Homeopathy
Introduction to the history, principles, clinical evidence and preparation of homeopathic remedies. Introduction to common remedies and their usage.
- **MODULE 2**
How to Counter Prescribe a Selection of OTC Homeopathic Remedies
Introduction to counter and keynote prescribing, building up knowledge of homeopathic remedies.
- **MODULE 3**
Using Homeopathy in First Aid Situations and Common Conditions
Introduction to the remedies suitable for first aid situations and other common conditions encountered in the pharmacy.
- **MODULE 4**
Prescribing Guide and Materia Medica
Prescribing guide and Materia Medica for help in choosing a medicine in simple, acute conditions encountered in the pharmacy.

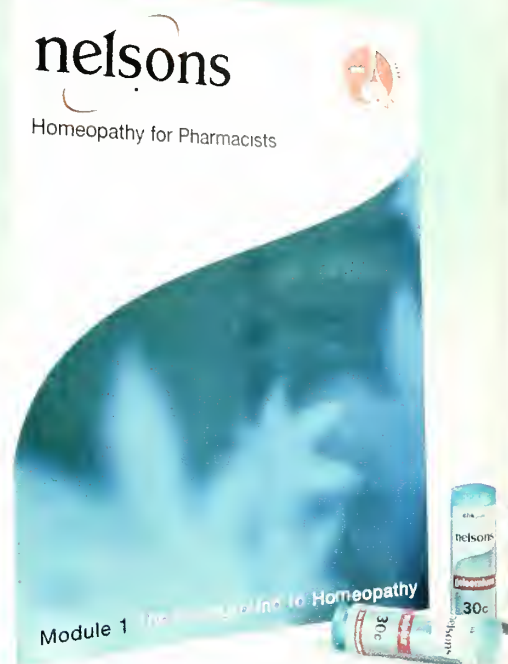
Successful completion of the four modules can provide approximately 8 hours of Continuing Professional Development (CPD) counting towards the 30 hours pharmacists need to undertake annually.

Pharmacists completing the four modules will be awarded Nelsons Official Stockist status and presented with a certificate, comprehensive Nelsons Guide and point of sale material. In addition to this they will also receive regional public relations support to raise their profile in the local community and drive business.

Modules one and two are now available. Pharmacists wanting to register for the course should contact:

Nelsons Homeopathy for Pharmacists Learning Modules
Freeport ANG8007
Precision House
Bury Road
Beyton
Bury St Edmunds
IP30 9ZZ

Alternatively call:
Freephone 0800 7836434
or e-mail: Nelsons@precisiondbm.com



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don't fit correctly," says Mr Prior.

Treatment

You should never burst a blister because it is meant to protect the skin from further trauma – bursting it could lead to infection. There are a number of blister plasters which provide a moist environment, which will allow the blister to heal by itself. "When wearing trainers make sure you tie the laces up tightly enough to prevent the foot moving around inside the shoe and causing friction," says Mr Prior.

If you're walking or running for long periods, apply blister plasters before you set out to prevent blisters developing.

"Wear a thin pair of socks and then a thicker pair over the top to absorb any friction. This will help prevent blisters," says Mr Prior.

Verrucas

Caused by a virus which enters the body via broken skin, verrucas affect one in 10 people. Usually found on the soles of the feet, they look like warts and may have a black dot in the centre.

Treatment

Around 60 per cent of verrucas will heal up by themselves within two years, and chiropodists now suggest doing this unless verrucas are causing pain. You can treat verrucas with plasters soaked in salicylic acid, or with the gel treatments which burn out the verruca. Never pick a verruca – it may spread to other parts of your foot.

Wear flip-flops around swimming pools and in wet changing rooms.

Sweaty feet

There are some 250,000 sweat glands in your feet, and most of us get sweaty feet in hot weather. Exercising can also cause sweaty feet, and this is exacerbated if you wear synthetic socks.

Treatment

For excessively sweaty feet, a specialist product, such as one containing aluminium chloride, should work. For less serious problems, apply surgical spirit to the feet and between the toes, then dust feet, shoes and socks with talcum powder to absorb perspiration. You could also use a foot antiperspirant.

Wear shoes and hosiery in natural fibres to allow your feet to breathe. Allow trainers to dry out between wearings.

The enemy within

The risk of DVT increases dramatically with age. Dr Indie Singh, Professor Kevin Burnand and Dr Alberto Smith explain the condition



A deep vein thrombus (DVT) is a semi-solid mass formed from the components of flowing blood in the deep veins of the body. The majority of venous thrombi arise in the deep veins of the legs and pelvis, but can occur in the upper limbs. The incidence of venous thrombi is thought to be approximately 0.5 per cent.¹

In 1856 Rudolph Virchow described three factors that he thought were important in the development of a DVT. The factors, referred to as Virchow's triad, are: 1) stasis or reduced blood flow, 2) changes in the lining of the vessel wall and 3) changes in the constituents of the blood (hypercoagulability).

Many studies have shown that the risk of DVT increases with age from one per 100,000 people per year in childhood to nearly one per 100 in old age. The incidence is thought to be equal in men and women. Some studies suggest that DVT is less common in warmer countries.² There are differences in the incidence of DVT between racial groups, eg caucasians of the USA and the Japanese.³ Some 30 per cent of patients undergoing major surgery over the age of 40 are at risk of developing DVT if no prophylactic measures are used.⁴

Patients with DVT classically suffer from calf pain, swelling and tenderness with a low-grade fever. Many DVTs however, do not cause symptoms. The presence of a DVT can damage the valves within the deep veins that

normally prevent reflux of blood. They may even totally occlude the vein lumen, resulting in calf pump failure. This is a condition where the calf muscles are unable to pump the blood up through the deep veins of the leg to the heart. This can result in the post-thrombotic syndrome.

The post-thrombotic syndrome affects up to 500,000 people in every 50 million.⁵ The clinical presentations of post-thrombotic syndrome include: aching legs, pain, varicose veins, pigmentation of the skin, eczema, ankle stiffness and ulceration.

Managing venous ulcers alone costs the NHS up to £400 million a year.⁶ In addition to the post-thrombotic limb, DVT is an important condition because it can lead to pulmonary embolism which can be fatal.

Several tests are available to help diagnose DVT. D-dimer (degradation product of fibrin) is a blood test which is a good tool for screening, but it has limited sensitivity and specificity. Other tests include:

- Duplex doppler – this is used to assess blood flow using B-mode and to see if the vein can be compressed.

- Ascending venography – this is an x-ray of the veins following an injection of contrast. It can demonstrate the presence of the thrombus as a filling defect.

- Impedance plethysmography detects venous thrombosis by measuring the maximum venous

outflow. It measures the changes in calf volume in response to upstream and downstream limb compression and the Valsalva manoeuvre. It is only 70 per cent accurate and is only of use as a screening test.

Other tests being developed include magnetic resonance imaging (MRI).

Once-daily injections of low molecular weight heparin (LMWH), eg FragminR, administered subcutaneously, have been shown to be at least as effective as conventional heparin and carry less risk of haemorrhage. Some patients are resistant to heparin and require higher doses. Others develop an immune response to heparin, which makes them thrombocytopenic and they may develop bleeding complications.

Warfarin inhibits the formation of vitamin K-dependent clotting factors (II, VII, IX and X) in the liver. A loading dose of warfarin is usually started within two to three days after starting heparin, followed by a maintenance dose to maintain the international normalised ratio (INR) between 2.0 and 2.5. In pregnancy, heparin is the anticoagulant drug of choice.

Warfarin treatment is usually maintained for three to six months unless there is an underlying congenital abnormality, such as antithrombin III deficiency, when it would be continued indefinitely.

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There is now clear evidence that early cessation of warfarin treatment leads to an increased risk of re-thrombosis.⁷

Thrombolysis has been shown to be partially effective in resolving fresh proximal venous thrombi. The only agent available at present is tissue plasminogen activator (tPA). The main complication of tPA is bleeding.

Surgical removal of the thrombus (thrombectomy) has never been subjected to a randomised control trial. It may be indicated for proximal fresh thrombus where there is risk of limb loss due to ischaemia (phlegmasia cerulea dolens), or if lytic therapy fails. Thrombectomy is associated with a high rethrombosis rate.

Vena cava filters prevent venous thrombi embolisation (pulmonary emboli). These are used in patients where anticoagulant therapy is contraindicated, or in patients who develop recurrent DVTs despite adequate anticoagulant therapy.

Early mobilisation, leg exercises and adequate hydration are encouraged after surgery.

Graduated compression stockings and intermittent pneumatic compression (IPC) boots have been shown to reduce the incidence of venous thrombosis after an operation. Pneumatic devices combined with graduated elastic compression stockings have been shown to have a synergistic action.⁸

A review of 15 randomised controlled trials of graduated compression stockings showed that stockings reduce the relative risk of DVT by 64 per cent in general surgical patients.⁹ Low dose (5,000 u bd) subcutaneous heparin has been shown to be effective in DVT prophylaxis. Low molecular weight

Risk factors for DVT

- Age
- Season
- Sex
- Race
- Occupation
- Type of operation
- Length of operation
- Type of anaesthetic
- Pregnancy
- Trauma
- Immobilisation
- Bed rest
- Malignancy
- Previous venous thrombosis
- Varicose veins
- Obesity
- Cardiac failure
- Arterial Ischaemia
- Myocardial infarction
- Contraceptive pill
- Drugs
- Vasculitis
- Congenital venous abnormalities

heparin fragments have also been shown to be as effective in preventing DVT and are associated with a reduced incidence of bleeding complications in the post operative period. Antiplatelet agents such as aspirin are of low but mild efficacy.¹⁰

There is circumstantial, but little epidemiological, evidence that passengers who travel on long haul flights have a higher incidence of DVT. Several retrospective studies report conflicting results. Eklof *et al* conducted a retrospective study of 254 passengers and found that 44 patients had developed a DVT and pulmonary embolism.¹¹

They identified five patient-related factors: history of previous DVT; malignancy or chronic disease; hormone therapy; recent lower limb injury; and recent surgery. They speculated about the role of cabin-related risk factors –

low humidity, hypoxia, diuretic effect of alcohol, insufficient fluid intake, smoking, "coach" position and immobilisation. Arvidsson¹² showed that 23 of the 25 patients with a DVT following air travel had predisposing risk factors, suggesting that the flight itself does not seem to be an important risk factor in healthy individuals. Parsi *et al*¹³ found that 72 per cent of all passengers who present with a DVT following long haul flight, are predisposed to DVT due to coagulation defects.

Kesteven and Robinson reported that the majority of venous thromboembolic disorders occurred in individuals with identifiable risk factors prior to their flight, and that sequential flights may increase the risk.¹⁴ Ferrari *et al*¹⁵ concluded that there was a fourfold increase in DVT following a journey lasting more than four hours, whatever means of transport was used. Lapostolle *et al*¹⁶ showed that a greater distance travelled by air is a significant risk factor for pulmonary emboli. Kraaijenhagen *et al*, however, reported a case control study showing that there was no increased risk of venous thrombosis among travellers.¹⁷

Only two prospective studies have been carried out to date. Scurr *et al*¹⁸ found that passengers travelling on flights longer than eight hours had a 10 per cent incidence of DVT. The Lonflit study¹⁹ showed that only the passengers who are already at high risk of DVT went on to develop a DVT following long haul flight (4.9 per cent).

The Lonflit-2 study has shown that wearing below-knee stockings reduced the risk of DVT by 18 times¹⁹. The study by Scurr¹⁸ has also shown that wearing elastic compression stockings during long haul flights is associated with a reduction in symptomless DVT.

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The future's digital

Is it worth moving into digital photoprocessing? One small Welsh pharmacy chain believes it is, as **Steven Webb** reports



Installing a DKS minilab has given Gareth James Pharmacy access to other markets, says its owner

News that Boots 'The Chemists' photoprocessing turnover fell 9 per cent last winter, due to the increasing popularity of digital cameras, won't have surprised Aberystwyth-based Gareth James Pharmacy.

The chain, which has five outlets – four of them offering photoprocessing – recently saw the power of digital photography when it acquired Photo-Me's new DKS digital minilab.

Gareth and Sue James have been involved in on-site photoprocessing for five years. Their first unit was a Photo-Me Imager minilab. Last year they took the plunge into digital when they saw the DKS at a Photo-Me roadshow in Cardiff. "We could not close our eyes to what it could offer our business: we were most impressed with the ease of operation, and in particular the print quality," he says.

Although the couple had not intended to buy another machine at that time, they decided the digital minilab was worth a try. They invested around £80,000 and installed the DKS minilab at the chain's Gorseinon branch, near Swansea.

"Since having the DKS installed, it has given us access to other markets. We tested the digital image processing service for ourselves by investing in a digital camera which we used on our holidays, and producing photos from its Smart card. The results were amazing, giving my shots a finish which compared to the work of a professional photographer," says Mr James.

Most demand for digital services comes from customers who want their images "written" onto a CD for their PCs. The pharmacy does not charge extra for digital processing and customers

pay the standard £4.99 for a 24-hour service (24 exposures).

However, Mr James believes that the true benefit of the DKS is the digital photo printing process: "There is less time-consuming input needed by my staff, compared with analogue machines, and they do not require a vast knowledge of colour management procedures to produce first class prints, as the scanner optimises the interpretation of the negative. There are no film channels to set as the equipment recognises all film brands.

"On top of that, we get much better output quality from low-quality negatives than was previously possible – even from negatives which have been damaged because of excessive heat.

As for customers who supply imperfect photos, the DKS automatically corrects under- or over-exposed shots, contrast and density imbalance, flash effects, backlighting and red eye. Its photo enhancement facilities also include increased image sharpness.

"This is an element not always appreciated by many minilab operations," says Pierre Buendia, general manager of Photo-Me International UK.

"Perhaps the analytical, pragmatic approach of pharmacists bring to all their business activity has made them more aware of the practicalities of such a system, but this is certainly a market sector which has reacted with great enthusiasm to the technology now being provided," he adds.

Mr James has found other benefits from the system: "Our throughput of one-hour service films has greatly increased due to the ease of use and speed of the machine, plus of course the confidence of the staff," he says.

"Another time-saving aspect is the archive feature, which is great, as we do not need to re-scan negatives to produce reprints."

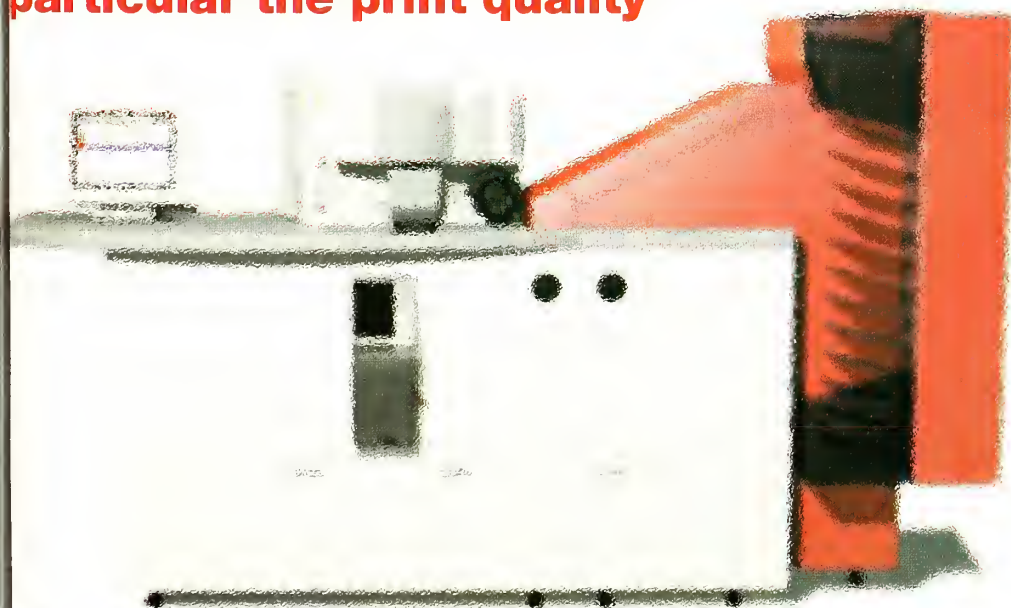
These benefits, he adds, have considerably improved staff time management, as well as profits, and the quality of print achieved from a single pass means there is less paper wasted.

The DKS takes up around one and a half square metres of floor space and, according to Mr James, it does not intrude into the pharmacy's ambience.

The system does not release the chemical odour often associated with minilabs. This is mainly because its chemicals do not have to be replenished too frequently, the tanks are fitted with an automatic maintenance system of the independent pumps, and it has automatic filtration and circulation of all baths with its compensation turnover system.

As a result, according to Mr James, the system is extremely easy to maintain. He adds that "margins on photography are very good – far better than on chemist lines!"

"We were most impressed with the ease of operation, and in particular the print quality"



For more information:
Gareth James Pharmacy
Tel: 01970 612 587
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780



Steve Wainman

Peter Shotter has joined Seven Seas as managing director. Mr Shotter previously worked for Boots The Chemists as director of healthcare businesses and most recently as director of stores. He succeeds **Clive Dixon**, who becomes chairman after 20 years as managing director.

Pharmacy technician **Cathy Moss** has been appointed as complaints advocate for the NHS in Wales. Ms Moss, who previously worked at the University Hospital of Wales, will be responsible for dealing with complaints from patients about hospitals, pharmacists, GP practices, dentists, opticians and community health services.

Rebecca Taylor, previously of IMS Health, has taken up post as assistant secretary general of the Pharmaceutical Group of the European Union.

There are two new faces at the Centre for

Pharmacy Postgraduate Education. **Janice Mason-Duff** becomes the centre's first full-time tutor and **Matthew Shaw** the assistant director. Mr Shaw was previously the community pharmacy coordinator for the NPA's professional development department.

Steve Wainman will be the new finance business manager for Phoenix Healthcare Distribution.

Jahn Dad Khan has been appointed clinical governance reviewer for the Commission for Health Improvement as part of the team looking at health authorities and PCTs. He is hoping to be involved in three reviews a year.

From April, **Mike Pilkington** will be product supply director for SSL International.

Christine Robinson will be the new head of the customer services team for Aventis Pharma.

Roll up for the next competition

As pharmacists the world over will have been rushed off their feet selling condoms this week (it was Valentine's Day on Thursday), this particularly tasteless list has arrived at *C&D's* office.

Allegedly, major retailers have started making their own condoms but kept their usual advertising slogan. For example:

- Sainsbury's Condoms – making life taste better.
- Tesco condoms – every little helps.
- Pringles condoms – once you pop, you can't stop.
- Andrex condoms – soft, strong and very very long.
- KFC Condoms – finger-licking good.
- Minstrels condoms – melt in your mouth, not in your hands.
- Ever Ready condoms – keep going and going.
- Renault condoms – size really does matter!
- Heineken condoms – reaches parts that other condoms just cannot reach.

And so it goes on... we'd love to rush a bottle of champagne to the person who provides us with the funniest pharmaceutical example, but try not to lower the tone too much – very naughty suggestions will go straight to the Statutory Committee. Send suggestions to: chemdrug@cmpinformation.com

Coast to coast

Gary Sawbridge, proprietor of the Beachwood Pharmacy in Liverpool, has helped to raise over £2,000 for a children's hospice by running, in relay, across the country.

Tired feet and aching limbs were common symptoms reported by Gary, his brother Richard and three colleagues as they each completed a leg of the 150-mile trip from St Bees in Cumbria to Robin Hood's Bay in North Yorkshire.

The team took turns in running five miles before handing over to another member while they recovered in the following van.



Mr Sawbridge is congratulated by Philip Bradley, marketing manager for Mawdsleys, one of the team's sponsors

Go on, show you have Vision...

Pharmacists are being encouraged to enter the Visions of Science Photographic Awards 2002. Apparently you don't have to be a white-coated scientist or an expert photographer with expensive equipment to enter. The four entry categories are:

- Science in Action – looking for images that capture science as it happens.
- Science as Art – for images that can stand alone as a work of art.
- Science Close-up – breathtaking imagery created by state of the art scientific equipment.
- Science Concepts – images that show a scientific subject or idea through the use of a



conceptual/abstract approach.

Within each category there will be three prizes: £1,000, £400 and £100. The competition closes on May 31. Further information about the awards, sponsored by Novartis and *The Daily Telegraph*, are available at www.visions-of-science.co.uk or call 020 7613 5577.

What a lot of bottle!

Leeds-based Rosemont Pharmaceuticals decided that money normally spent on Christmas cards and gifts would be much more useful as a donation to a local hospice. Maureen Burns, of the Martin House Hospice for Children and Young People, was delighted to receive this uniquely-shaped cheque for £2,000 from Dr Andre Groenewage, MD of Rosemont. The money will go towards the hospice's "Place for Us" appeal to build a new six-bed teenage unit. Do all Rosemont cheques look like this?



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Northern Ireland pharmacists enrolling for Update before the end of February will have their registration fee paid by the NI Centre for Pharmacy Postgraduate Education and Training

Just complete the coupon and send it with a cheque for £20.00 (£17.02 + VAT). Alternatively, call Mary Prebble on 01732 377269 with your credit card details. This will register you for 12 months' worth of certificated marking. After February 16, the standard registration fee for Update will be £25.00.

For further information, contact Mary Prebble on 01732 377269.

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